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ARMY FAMILY HEALTH SEEKING BEHAVIOR AND SATISFACTION

ANNUAL REPORT

OTTO VON MERING

AUGUST 10, 1989

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U.S. ARMY MEDICAL RESEARCH AND DEVELOPMENT COMMAND
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OVERVIEW OF RESEARCH ACTIVITIES

A. PHASE I: Client Interview Survey

A-1. Summary and Update of 3/27/89 Interim Report:

As noted in the Interim Report of 3/27/89, 801 interviews were conducted with clients in outpatient clinics at WINN hospital, the TUTTLE clinic, PRIMUS, and Dental Clinic I.

The closed-ended questions were coded and entered into a computer file. The data have been entered into a data set using the Statistical Analysis System, and analyses of this data are in progress. Content analysis procedures on the open-ended questions are also well underway.

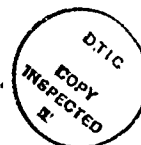
Throughout this study, the research objective has been to combine quantitative and qualitative data and techniques not only for cross-checking purposes, but to arrive at a holistic interpretation of Army health care. At the present time, quantitative and qualitative analyses of the client interview surveys are being carried on separately, but they will be combined in the final analysis and report. (Sylv) T

A-2. Data Set "Cleaning" Process of Close-ended Responses:

In the Interim Report of 3/27/89, we noted that the first step in data cleaning, correcting all out-of-bounds and invalid data punches, had been completed, and that cross-tabulation consistency checks were underway. These checks have now been completed and the data-cleaning process concluded.

The cross-tabulation consistency checks are based on bivariate relationships. These, in turn, were suggested by the structure of the questionnaire to determine inconsistencies in the data set. Certain questions should have been asked only of respondents who "passed through" previous "gate" questions. For example, only active duty respondents should have provided the year in which they entered the army. Inconsistencies in these answer patterns indicated mis-coding or interviewer error. The original interview schedules were used to resolve inconsistencies. For an example of this process, see Document 1.

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A-3. Preliminary Data Analysis of Close-ended Responses:

A-3a. Descriptive Summary of Client Demographics:

A demographic description of client interviewees has been computed for each clinic where client interviews were carried out. This data is represented in two tables, one for the Ft. Stewart/Hinesville area clinics (Document 2) and one for the Savannah area clinics (Document 3). An accompanying narrative (Document 4) elaborates on the tables. This information provides a general overview of demographic characteristics of the 801 client interviewees.

A-3b. Life Course Analysis:

This analysis consists of a description of respondents and their families and has an important substantive goal. One of the prime reasons for undertaking this study is the need to understand the effects of the growing diversity in army families on patterns of uses and satisfaction with health care. The description of the range of families is an important first step in achieving our substantive goal.

The analysis also has an important methodological motivation. In analyzing the life course patterns of health care, it is very important to capture important dimensions without repeating the same information. For example, age and years on active duty are so highly correlated that they represent virtually the same thing.

The analysis suggests that five characteristics capture the main dimensions of the life course, without redundancy: three levels of rank (E1-E4; E5 and above; Warrant and officer grades); marital status; presence of a child under six in the household; the distinction between active duty and family member; and years of schooling. A narrative description (Document 5) and tables (Document 6) describe the range of variation in the client sample.

A-3c. Provisional Analysis of Clinic Variations:

We are currently analyzing the client interview data to examine differences among clinics. The initial goal is to identify two kinds of clinic differences: differences in types of patients and differences in use patterns. To-date, the analysis has focused on life course differences in patients and patient reports of what happens in the clinic. The findings of this analysis will then be pursued by combining these data with other data sources in this project. Details of the preliminary analysis of the differences between two clinics, the Winn emergency room and the Primus clinic, are reported in Documents 7, 7a, 7b, 7c.

A-4. Content Analysis of Open-Ended Responses:

Work on the qualitative analysis of the open-ended questions of the client interview has been focused on developing thematic and mechanical conventions and writing a code manual for the analysis of the responses. Other related activities have included preparation of the transcribed data for analysis and selection of computer software for the entering and management of the coded data.

This in-process report has been prepared especially with the purpose of introducing the reader to the complexities of doing proper scientific content analysis.

A-4a. Development of Thematic Categories and Coding Procedures

Using the major themes derived from the data-reduction phase of the open-ended client interview questions, the research team has developed a method to code each open-ended question according to the major issues it represents. This was accomplished by defining a series of identifiers and specifiers which represent important issues, circumstances, and conditions of Army medicine. A set of conventions were designed to record the presence or absence and the value attributed to these issues by the respondents. These conventions will be entered into a computer data base and will constitute the basis for subsequent interpretation and analysis (see Documents 8, 8a, 8b, 8c).

Presently, the bulk of our time has been devoted to completing the Dictionary of Terms (Document #9) and The Guide of Coding Conventions (Document #10) which will be two principal sections of the code manual. Upon completion, the manual will include an overview of the coding procedure, definitions of all the themes and sub-themes, directions for entering the codes into the computer, and examples of interpretation and selection of conventions for each question. The code manual will be of primary importance not only in the coding of the responses but also in training the coders and in the final interpretation of the data.

A-4b. Coder Training and Inter-rater Reliability Testing

At the expected completion of the first draft of the code manual in September we will begin training the coding staff and testing inter-rater reliability. We expect to use the completed code manual as the primary tool for training. A training period of approximately a week will be scheduled during which time each coder will review the code manual and then practice coding with the guidance of the content analysis staff member. Inter-rater reliability will be established by acquiring a consensus among the coders on the coding of 10% of the total client interviews (approximately 80 interviews). We are retaining a former content

analysis team member to participate as an "outside" rater in order to ensure objectivity and reliability of the coding manual and procedure.

A-4c. Data Preparation and Management

To prepare for the application of the designed coding procedures, the content analysis staff met with a computer consultant in July regarding two key issues, including the preparation of the data for analysis and the selection of a data-base management computer program. The consultant advised us to use R-Base for the entering and data management of the coded data. He also advised us on how to "clean" and re-aggregate the transcriptions of the open-ended questions and is writing a program to upload our data files to R-Base. At this time, "cleaning" of the data is in-progress and is expected to be completed by the end of September (see Document 11). We have also purchased R-Base and are beginning to train this month. Our consultant will be retained until we have completed the design of our data management application which is tentatively scheduled for late Fall.

B. Phase II. Provider Interview Survey

B-1. Summary and Update of 3/27/89 Interim Report.

The provider/primary contact person interview was constructed "from the ground up." None of the items used were derived from existing questionnaires. The formal start of the Phase II provider interviews began on March 9, 1989 and interviewing was concluded on schedule, on June 9, 1989. 199 interviews were completed. These took place in all of the targeted clinics (e.g. those where the client interview survey had been carried out), as well as in a few additional clinic sites. Interviewing both clinic users and health care providers gives a holistic perspective of Army health care. Data from both phases will eventually be compared and combined in the final analysis.

B-2. Scheduling and Tallying of Provider Interviews.

To interview primary health care providers and clinic service staff, the cooperation of the clinic administrators in scheduling interviews was crucial. Through advance planning and consultation with the administrators (see interim report for scheduling details), interviewing dates and schedules were agreed upon and interviews successfully completed (Document 12). A description of the clinics and providers who participated in this phase (Documents 13, 13a, 13b, 13c) indicates that a good distribution of respondents in the various clinics was interviewed. A more detailed count will be made when data from all the provider interviews is coded into the computer.

B-3. Construction of Codebook for Close-Ended Responses; Coding Procedures, and Scheduling of coding.

The codebook for the quantitative data from the provider interviews has been completed (Document 14). These data include closed-ended items as well as those other items on which coder judgment is not a highly relevant factor. Upon completion of coding of the open-ended items, the two types of data from the provider interviews will be merged into one data set. Data from the provider interviews are now being keypunched. Two coders (graduate research assistants) work together in entering the data and weekly schedules for coding are arranged between the students (Document 15).

B-4. Data Analysis Priorities for Provider Quantitative Data:

Following the coding of all quantitative data, the data will be cleaned using the same procedure as with the client interviews. First, data will be inspected for illegal punches and the appropriateness of missing data allocations will be

examined. Next, consistency checks across bivariate distributions will be examined. Data analysis priorities are:

1. A descriptive profile that will compare: a) different types of providers (e.g. physicians vs. technicians); and b) different clinics. The issues that will be considered are: a) career plans; b) views on who gets care; c) orientation toward care; and d) perceptions of problems with military care.

2. Based on the results of the descriptive analysis, the next focus will be on tying the results of the patient interviews with the provider interviews. For example, are there differences in clinics, as perceived by patients, that are mirrored in responses of providers? While it is possible that there will not be large clinic differences among providers because of the large amount of mobility in the military, similar issues can be addressed with the entire sample. For example, is there a disjunction between expectations of providers and those of patients?

3. A third area of quantitative analysis will be responses to questions about their own health care that are asked of providers. These can be compared to the responses of patients.

4. Formal merging of the findings from the close-ended and open-ended responses will be a main priority during the final analysis phase of this project.

B-5. Content Analysis of Open-ended Responses.

This phase will follow the same format as the content analysis of the open-ended questions in progress for the client interviews as discussed in detail in Section A-4.

C. Phase III. Content Analysis of Documents and Media Reports.

C-1. Summary and Update of 3/27/89 Interim Report.

Data for content analysis is divided into three levels, as discussed in the Interim Report. The first level includes open-ended answers from the client and provider interviews, and interviewer fieldnotes from both client and provider interview phases. The other levels consist of documentary data as follows: 1.) internally generated data: e.g. by the medical administration at the field site, including committee meeting notes, and an in-house survey; and 2.) externally generated data consisting of: newspaper articles relating to Army health care and related issues from both military and civilian media, and a variety of journal articles addressing a number of health related issues.

The first level of data was collected on site by the field staff through interviews, informal conversations and field observations. As described in Section A-4, thematic analysis of open-ended responses on the client surveys has been completed. We expect that the themes present in each level of data will expand on those found in the on-site data, and that this will reflect a flow of information from the level of the patient and provider to interviewer fieldnotes, administrators' meetings and finally the news media. Thus, we expect that the review of subsequent levels of data will both confirm and inform the thematic categories established thus far. We have focused efforts thus far on the analysis of the open-ended client interview responses (see section A-4), since interpretations of the other levels of document and media data will be related to the analysis of the level one data.

C-2. Content Analysis of Interviewers' Fieldnotes:

As discussed in the Interim Report of 3/27/89, fieldnotes were made by the interviewing staff during both the client and provider survey phases. Preliminary content analysis of the fieldnotes written during the provider interviewing phase, from March to June, 1989, reflect related and additional themes to those found in the fieldnotes from the client interviewing phase (Document 16).

The importance of field note data in the overall research design is discussed in detail in the Interim Report of 3/27/89. Basically, the validity of conclusions from any one area of data depends on the extent to which they are supportable by different layers of data, and the field notes provide yet another type of data for cross referencing.

Several specimen fieldnotes from the provider interview phase are attached (Documents #17 and 18).

C-3. Content Analysis of WINN Committee Meeting Notes:

WINN hospital committee meeting notes for the following four committees have been collected over a two year period from June, 1987 to July 1989:

- 1.) Hospital Advisory Committee;
- 2.) Marketing/Strategy and Planning Committee;
- 3.) Health Care Consumer Committee;
- 4.) Health Promotion Committee.

These committees were selected for analysis by the Principal Investigator, Dr. Otto Von Mering, because they are attended by both MEDDAC and DENTAC Commanders. They, therefore, document the central concerns of Army medical management.

We are interested in exploring how the the official "We Care People" image compares with consumer perceptions of the care receiving experience. At present, a careful recount of the meeting notes indicates we have collected a total of 83 monthly notes from June 1987 to June, 1989 (Document # 19). A thematic content analysis will soon begin.

C-4. Content Analysis of In-house Survey:

An in-house survey of staff perceptions and satisfaction at the WINN hospital was conducted by WINN staff in the Spring of 1988. At the request of the MEDDAC Commander, Col. Juan Garcia, the WRAIR research team is reviewing the survey results, and applying content analysis procedures for additional systematic interpretations. This process is currently underway and a preliminary report has been made (Documents #20, 20a, 20b, 20c, 20d). A final report will be sent to WINN MEDDAC Command Col. Garcia, and information from this survey will contribute to the WRAIR data bank.

C-5. Content Analysis of Newspaper Articles:

The WRAIR/UF research team began to carefully scrutinize issues of the Army Times in June, 1987. We also collected issues of the Patriot, the local Ft. Stewart weekly newspaper, and have requested back issues of the Mercury from 6/87 to 6/89. From these newspapers, articles pertinent to Army family health care are copied, categorized, filed in a notebook, and titles entered on a computer disk. Simultaneously, pertinent articles from the civilian press are also copied and collected in a separate notebook as a basis for comparison of how specific issues are treated by the representative media. To date, approximately four hundred articles have been collected and grouped into fourteen major categories (Docur t# 21). A preliminary content analysis

of the titles of the Army Times articles reveals a concern with varying issues in each of the general categories as described in Document # 22.

C-6. Content Analysis of Journal Articles:

Journal articles and other published reports and documents relevant to military health care, general health and medical issues, and research methodology have been collected and filed since the inception of the project. Graduate student assistants read and write one page abstracts of these materials, as well as notes and queries relating the issues addressed in each article or report to concerns of the WRAIR study of Army health care (for examples, see Documents #23 and 24). Content analysis of these abstracts has not yet begun.

D. Phase IV. Mail Survey of Health Service eligible Army Family Members

D-1. Summary and Update from 3/27/89 Interim Report:

The project research design calls for the administration of a final mail survey instrument with items selected from the previous Phase I and Phase II interview questionnaires. The research staff is currently collaborating on the construction of the mail survey, with each of the four staff members (Von Mering, Henretta, Hendry and Neal) who have long-term familiarity with the project selecting possible questions for inclusion in the mail survey. Questions from both the Phase I Client Interview Survey and the Phase II Provider Interview Survey will be adapted for the mail survey. The administration of this instrument will be based on the Dilmon (1978) technique and entails four mailings within a 4 to 5 week period to be assured a reasonable 65/75% response rate. Further methodological considerations pertaining to the prospective mail survey of health service eligible Army Family members are discussed in more detail in Document #25. A tentative schedule of target dates for the mail survey process has also been formulated (Document #26).

E. Special Explanatory Statements

E-1. 6/6/89 Provisional Report to Provost and Vice President of Academic Affairs of University of Florida:

A special status report of this project (see Document #27) was prepared at the request of the top university administrators concerned with public relations with the Florida legislature. The report was prepared to satisfy the special interests of the Vice President of Academic Affairs who is concerned with the application of the WRAIR research project to health care delivery problems of the U. S. Navy.

E-2. Retrospective Commentary of Project Preparatory Site Visits:

This document (document #28) is included at this time to reiterate a point made previously about proper research procedures for projects of the kind undertaken by the research team for Walter Reed. This point concerns the necessity of building salient issues and concepts into project research instruments from the ground up. While we stressed before the importance of field work and observation, we did not stress specifically the need for a long series of brief initial fact finding interviews indicative of the overall structure and processes of a complex health care organization. Moreover, we did stress previously that this procedure helped build the necessary rapport to carry out long lasting (approximately one hour) interviews with providers and clients.

E-3. Budgetary Comments:

The overall interviewing process involving 1,000 subjects was highly cost effective for the unit cost, except for the data generation on the providers for which the hiring of "medical professionals" to do provider interviews was required in order to obtain MEDDAC authorization for interviewing clinical provider personnel and high administrative personnel. This necessitated the sub-contract employment of two nurse practitioners who had to be paid on an hourly basis of \$25.00 per hour (see Document #29 for summary budget statement). A detailed breakdown of costs for graduate students is not necessary since maximum compensation never exceeded \$8.75 per hour. In conclusion, the competence of well trained and well motivated graduate student research assistants with prior field experience in a variety of cultural and organizational settings has an invaluable advantage over temporary contract employees.

DOCUMENT PREPARATION

1. **Document #1:** Example of data set cleaning process of close-ended responses: Prepared by Brandon Wallace in consultation with John Henretta
2. **Documents #2, 3, 4:** "Descriptive Summary of Client Demographics" and accompanying Tables: Prepared by Brandon Wallace in consultation with Otto Von Mering
3. **Documents #5, 6:** "A Portrait of Military Families by Rank Based on Client Interview Data" and accompanying tables: Prepared by Brandon Wallace in consultation with John Henretta
4. **Documents #7, 7a, 7b, 7c:** "A Comparison of Two Clinics: Winn Emergency Room and Primus" and accompanying tables: Prepared by John Henretta in consultation with Otto Von Mering, Barbara Hendry and Brandon Wallace
5. **Documents #8, 8a, 8b, 8c, 9, 10, 11:** Documents and tables related to content analysis of open - ended responses on the client interviews: Prepared by Susannah Neal in consultation with Otto Von Mering and Margaret Norris
6. **Documents #12, 13, 13a, 13b, 13c:** Documents relating to the scheduling and tallying of provider interviews: Prepared by Susannah Neal in consultation with Barbara Hendry and Otto Von Mering
7. **Document #14:** Codebook for close-ended responses of provider interviews: Prepared by Barbara Marriott and John Henretta
8. **Document #15:** Sample coding schedule sheet: Prepared by Susannah Neal
9. **Documents #16, 17, 18:** Documents relating to content analysis of interviewers' fieldnotes from provider interview phase: Prepared by Barbara Hendry and Susannah Neal
10. **Document #19:** Count of Winn Committee Meeting notes in WRAIR files: Prepared by Lois Randolph
11. **Documents #20, 20a, 20b, 20c, 20d:** Documents relating to analysis of WINN In-house survey: Prepared by Lois Randolph in consultation with Otto Von Mering
12. **Documents #20, 21:** Documents relating to content analysis of newspaper articles: Prepared by Lois Randolph
13. **Documents #23, 24:** Examples of abstracts of journal articles: prepared by Barbara Hendry

14. Document #25: "Further Methodological Considerations Pertaining to the Mail Survey": Prepared by John Henretta in consultation with Otto Von Mering

15. Document #26: Tentative schedule of target dates for mail survey process: Prepared by John Henretta and Otto Von Mering

16. Document #27: "Provisional Report to Provost and Vice President of Academic Affairs of University of Florida": Prepared by Otto Von Mering and Lois Randolph

17. Document #28: "Retrospective Commentary of Project Preparatory Site Visits": Prepared by Lois Randolph in consultation with Otto Von Mering

18. Document #29: Budget related invoice: Prepared by Betty Goodson in consultation with Otto Von Mering

Example of data set cleaning process of close-ended responses:

TABLE I.

An example: The table below cross-tabulates whether a respondent is a current smoker by whether he or she has ever smoked. Only those who respond "no" to the current smoker question should have been asked if they ever smoked.

<u>Current smoker</u>	<u>Ever smoked</u>		
	Missing	Yes	No
Missing	27	1	0
Yes	286	1	3
No	9	155	319

As the second line of the above table indicates, 286 respondents who currently smoke are correctly coded as missing on "ever smoked." Four current smokers were improperly coded with valid responses on "ever smoked." The interview schedules for these respondents were examined to determine the appropriate correction. The structure of the questionnaire allowed several similar consistency checks.

Note that 27 respondents had no responses for either question. These are mostly cases in which the interview is incomplete because the respondent was called away for his health-care visit. Ten respondents are missing on only one of the variables, most likely as a result of interviewer error.

DESCRIPTIVE SUMMARY OF CLIENT DEMOGRAPHICS BY CLINIC WHERE INTERVIEW WAS CONDUCTED (N=801).
 CELLS REPRESENT NUMBER AND PERCENT OF RESPONDENTS IN EACH CATEGORY.
 (MEAN AND STANDARD DEVIATION GIVEN FOR AGE AND EDUCATION.)

FT. STEWART/HINESVILLE AREA CLINICS

	DENTAC N=75	EMERGENCY N=151	FAMILY PRAC N=80	OUTPATIENT N=16	PEDIATRICS N=94	OB/GYN N=100	TOTAL N=516
ACTIVE DUTY	50 (66.7)	72 (47.7)	53 (66.3)	5 (31.3)	24 (25.5)	18 (18.0)	222 (43.0)
FAMILY MEMBERS	16 (21.3)	65 (43.0)	20 (25.0)	7 (43.8)	68 (72.3)	78 (78.0)	254 (49.2)
RET/FM RET	9 (12.0)	14 (9.3)	7 (8.8)	4 (25.0)	2 (2.1)	4 (4.0)	40 (7.8)
OFFICERS	8 (11.6)	5 (3.7)	5 (7.1)	2 (16.7)	8 (8.9)	4 (4.5)	32 (6.9)
LOWER ENLISTED	23 (33.3)	65 (47.8)	42 (60.0)	4 (33.3)	35 (38.9)	54 (61.4)	223 (47.9)
HIGHER ENLISTED	38 (55.1)	66 (48.5)	23 (32.9)	6 (50.0)	47 (52.2)	30 (34.1)	210 (45.2)
NOT MARRIED	18 (24.0)	27 (17.9)	25 (31.3)	3 (18.8)	4 (4.3)	9 (9.0)	86 (16.7)
MARRIED	57 (76.0)	124 (82.1)	55 (68.8)	13 (81.3)	90 (95.7)	91 (91.0)	430 (83.3)
NO KIDS	36 (48.0)	50 (33.1)	35 (44.3)	5 (31.3)	1 (1.1)	42 (42.9)	169 (33.1)
KIDS UNDER 6	21 (28.0)	74 (49.0)	35 (44.3)	8 (50.0)	75 (81.5)	41 (41.8)	254 (49.7)
KIDS 6 OR OVER	18 (24.0)	27 (17.9)	9 (11.4)	3 (18.8)	16 (17.4)	15 (15.3)	88 (17.2)
FEMALE	23 (30.7)	87 (57.6)	51 (63.8)	12 (75.0)	79 (84.0)	100 (100.0)	352 (68.2)
MALE	52 (69.3)	64 (42.4)	29 (36.3)	4 (25.0)	15 (16.0)	0 (0.0)	164 (31.8)
WHITE	50 (67.6)	96 (65.3)	46 (58.2)	12 (75.0)	57 (62.0)	70 (70.0)	331 (65.2)
NON-WHITE	24 (32.4)	51 (34.7)	33 (41.8)	4 (25.0)	35 (38.0)	30 (30.0)	177 (34.8)
LIVE ON POST	25 (38.5)	56 (43.8)	25 (33.8)	2 (18.2)	21 (25.3)	21 (25.9)	150 (33.9)
LIVE OFF POST	40 (61.5)	72 (56.3)	49 (66.2)	9 (81.8)	62 (74.7)	60 (74.1)	292 (66.1)
AGE	31.5 (10.4)	27.9 (8.7)	28.8 (10.5)	33.6 (14.2)	27.1 (5.8)	25.2 (8.5)	28.1 (9.2)
EDUCATION	13.0 (1.6)	12.5 (1.3)	12.6 (1.6)	13.1 (1.6)	12.4 (2.0)	12.2 (1.6)	12.6 (1.6)

SAVANAH AREA CLINICS

	PRIMUS N=180	TUTTLE N=51	AVIATION N=54	TOTAL N=285
ACTIVE DUTY	39 (21.7)	46 (90.2)	45 (83.3)	130 (45.6)
FAMILY MEMBERS	79 (43.9)	2 (3.9)	7 (13.0)	88 (30.9)
RET/FM RET	62 (34.4)	3 (5.9)	2 (3.7)	67 (23.5)
OFFICERS	17 (13.5)	0 (0.0)	7 (13.5)	24 (10.6)
LOWER ENLISTED	35 (27.8)	36 (75.0)	9 (17.3)	80 (35.4)
HIGHER ENLISTED	74 (58.7)	12 (25.0)	36 (69.2)	122 (54.0)
NOT MARRIED	20 (11.1)	28 (54.9)	15 (27.8)	63 (22.1)
MARRIED	160 (88.9)	23 (45.1)	39 (72.2)	222 (77.9)
NO KIDS	60 (33.5)	35 (70.0)	23 (42.6)	118 (41.7)
KIDS UNDER 6	59 (33.0)	9 (18.0)	16 (29.6)	84 (29.7)
KIDS 6 OR OVER	60 (33.5)	6 (12.0)	15 (27.8)	81 (28.6)
FEMALE	121 (67.2)	19 (37.3)	10 (18.5)	150 (52.6)
MALE	59 (32.8)	32 (62.7)	44 (81.5)	135 (47.4)
WHITE	127 (70.9)	28 (54.9)	46 (86.8)	201 (71.0)
NON-WHITE	52 (29.1)	23 (45.1)	7 (13.2)	82 (29.0)
LIVE ON POST	32 (25.8)	24 (52.2)	11 (21.6)	61 (28.4)
LIVE OFF POST	92 (74.2)	22 (47.8)	40 (78.4)	154 (71.6)
AGE	36.3 (14.8)	26.6 (11.5)	31.4 (7.2)	33.6 (13.6)
EDUCATION	13.1 (1.9)	12.7 (1.6)	14.0 (2.0)	13.2 (1.9)

Notes:

1. The sum of some cells may not add up to the total sample size due to presence of missing values.
2. RET/FM RET includes retirees and the family members of retirees.
3. Rank was assigned to family members according to the rank of the person on whom DEERS eligibility is based.
4. Lower enlisted includes ranks E1 through E4. Higher Enlisted includes E5 through E9 and W1 through W4.
5. NOT MARRIED includes single, widowed, divorced, and separated.
6. KIDS 6 OR OVER includes all respondents with children at home, but with none under 6 years old.
7. EDUCATION is given in number of years completed.

Descriptive Summary of Client Demographics:

Of the 801 client interviews conducted by the WRAIR research team, 516 were located in Ft. Stewart/Hinesville area clinics including Dentac and the various clinics of the Winn Army Medical Center. The other 285 client interviews were located in either Primus, Tuttle, or Aviation clinics in the Savannah area. Almost half of the interviews in the Hinesville area clinics were with family members of active duty personnel (45.6%) while less than a third of the interviews in the Savannah area clinics were with family members (30.9%). Retirees were only a small portion of the interviews in Hinesville (7.8%), but approached one quarter of those conducted in Savannah (23.5%). The largest portion of retirees were interviewed in Primus (34.4% of Primus N=180).

Few officers or their family members were interviewed in either the Savannah or Hinesville areas. Most (47.9%) of the interviews in the Hinesville area were with lower enlisted persons (ranks E1-E4) and their families, while in the Savannah area most (54.0%) were with higher enlistees (ranks E4-E9 and W1-W4). In the Hinesville area, interviews conducted in both Family Practice and OB/GYN were largely with lower enlistees (60.0% and 61.4% respectively) while in other clinics more higher enlistees were interviewed. In the Savannah area the difference between clinics is more marked with 75% of the interviews conducted in Tuttle being with lower enlistees but only 27.8% and 17.3% of interviews conducted in Primus and Aviation respectively being with lower enlistees or their families.

Over three quarters of the persons interviewed in both areas were presently married (83.3% in the Hinesville area and 77.9% in Savannah) and in some clinics (Pediatrics, OB/GYN, Primus) the percentage married was about 90%. A third of those interviewed in the Hinesville area had no children (33.1%), almost half had a child under 6 (49.7%), and only 17.2% had children at home that were not under 6. The only clinic in this area that is particularly different from the others is pediatrics where 81.5% of those interviewed had children under 6. In the Savannah area, on the other hand, 41.7% of those interviewed had no children while only 29.7% had a child under 6, and 28.6% had a child at home that was not under 6. Tuttle stands out among the Savannah area clinics since 70% of those interviewed reported having no children.

Females were interviewed more often than males in all clinics in the Hinesville area except Dentac where males outnumbered females 2 to 1. As might have been expected, all interviews conducted in OB/GYN were with females. For the Savannah area clinics, females outnumbered males only in Primus where twice as many females were interviewed as were males. In both Tuttle and Aviation, the number of females interviewed was significantly lower than the number of males, especially in

Aviation where only 18.5% of the interviews were with females. Thus, while the overall number of interviews conducted with females in the Savannah area was greater than the number conducted with males, three quarters of the females interviewed in this area were interviewed in Primus.

In the Hinesville area, the number of whites interviewed in each clinic was greater than the number of non-whites with the proportion of non-whites ranging from 25% in the Outpatient clinic to 41.8% in Family Practice. The overall proportion of non-whites interviewed in the Hinesville area was 34.8%. For the Savannah area clinics, the whites again outnumbered non-whites but the variability between clinics is more substantial. While only 13.2% of the interviews conducted in Aviation were with non-whites, 29.1% of those conducted in Primus, and 45.1% of those conducted in Tuttle were with minorities. The overall proportion of interviews conducted with non-whites in Savannah area was 29.0%.

The proportion persons interviewed in the Hinesville area who lived on post ranged from only 18.2% in the Outpatient clinic to 43.8% in the emergency room. These figures differ substantially from the other Winn clinics (excluding Dentac where 38.5% lived on post) which ranged from 25.3% in Pediatrics to 33.8% in Family Practice. Overall, roughly a third (33.9%) of those interviewed in the Hinesville area lived on post. Again, there are distinct differences among the clinics in the Savannah area. For Primus and Aviation, the proportion living on post was 25.8% and 21.6% respectively while for Tuttle this proportion was 52.2%. The overall proportion of those interviewed who were living on post was 28.4%.

The average age of persons interviewed in the Hinesville area clinics was 28.1 years and with OB/GYN having the youngest average age 25.2 years and the Outpatient clinic having the oldest at 33.6 years. The only other Hinesville clinic with an average age over 30 was Dentac at 31.5. In the Savannah area, the average age was somewhat higher at 33.6 years. Both Primus (36.3) and Aviation (31.4) had average ages over 30 and Tuttle had the youngest average age at 26.6. Persons interviewed in the Hinesville area clinics averaged 12.6 years of school, with respondents from the Outpatient clinic and Dentac having the highest average education at 13.1 and 13.0 years respectively and those from OB/GYN having the lowest at 12.2. In the Savannah area, Tuttle had an average educational level of 12.7 years, Primus was at 13.1 years, and Aviation was highest at 14.0 years. The overall average was 13.2.

A Portrait of Military Families by Rank
Based on Client Interview Data

Lower Enlisted (Ranks E1-E4)

Age of Respondents:

The average age of lower enlisted active duty persons (LE/AD) in the sample was 22.5 years (SD=3.0). Most (78.73%) were under the age of 25 while 17.82% fall between 25 and 29 inclusive and 3.45% are 30 or over. For family members of lower enlisted personnel (LE/FM) the average age was 23.2 years (SD=4.1). In the FMs case, 69.42% were under 25, 23.97% were between 25 and 29, and 6.61 were 30 or over.

Time in Military Service:

LE/ADs have been in the military a relatively short time. The average length of military service was 2.8 years (SD=2.1) with 31.76% having been in one year or less and 74.11% having been in three years or less. Only 8.83% had been in for more than five years. The LE/FMs reported an average length of service of 3.3 years (SD=2.5) with 23.31% having been in one year or less, 71.52% having been in three years or less, and only 18.75% having been in more than five years.

Marital Status:

Of the LE/ADs interviewed, 52% were presently married or living with someone. The other 48% were either divorced, separated, widowed, or single. All LE/FMs were married.

Length of Marriage:

Most LE/ADs reported that they had been married relatively recently. The average length of an LE/AD marriage was 2.2 years (SD=2.1) with 44.79% having been married one year or less and 85.42% having been married 3 years or less. For LE/FMs, the average length of time married was 3.0 years (SD=2.3) with 23.81% reporting being married 1 year or less and 66.67% reporting being married 3 years or less. Another 19.84% of LE/FMs reported that they had been married between 4 or 5 years.

Number of Children:

Since many of the LE/ADs were not married, only 34.29% reported having children in their home with 31.43% having one or two children and 2.86% having 3 or more. The average number of children for LE/ADs was .8 (SD=1.1). However, for LE/FMs, all of whom were married, the percentage having children at home was 73.6% with 64% having one or two children and 9.6% having 3 or more. The average number of children for LE/FMs was 1.2 (SD=1.0).

Age of Youngest Child:

For those LE/ADs with children, the average age of their youngest child was 2.2 years (SD=2.5) with 81.67% reporting

at least one child under the age of three and 91.67% reporting at least one child under 6. For LE/FMs, the average age of youngest children was 2.2 years (SD=2.2) with 76.09% having a child under 3 and 95.66% having one under 6.

Age of Oldest Child:

The average age of the oldest child for LE/ADs was 3.8 (SD=3.5) with 63.33% of the LE/ADs having their oldest under 3 years old and another 15% reported their oldest child as being between 3 and 5 inclusive. While 21.67% of LE/ADs report their oldest child as between 6 and 12, only 1.67 report children over 12. For LE/FMs, the average age of the oldest child is 3.8 years (SD=3.5) with 52.17% reporting their oldest child as being under 3 and 23.91% reporting their oldest as being between 3 and 5 inclusive leaving 20.65% with children between 6 and 12 and 3.26% with children over 12.

Education:

The education level of LE/ADs was moderate with average number of years of education being 12.5 (SD=1.1). Only 1.74% had less than a high school education. Most (68.60%) were high school graduates, and 29.64% had at least some college. LE/FMs had slightly lower figures averaging 12.0 years of education (SD=2.1) with 20.49% not having finished high school, 54.92% being high school graduates, and 24.59% having at least some college.

Employment Status of Non-AD Spouse:

Of the LE/ADs that were married, 45.16% reported that their spouse was employed while for LE/FMs this figure was only 27.42%. Perhaps this suggests that when employed, FMs are less likely to use military health care.

Housing:

While 42.68% of LE/ADs reported living on post only 24.35% of LE/FMs did so. This difference may be due to single respondents in the AD sample being more likely to live on post.

Active Duty Spouse:

Active duty spouses were reported by 28.28% of LE/ADs.

Higher Enlisted (Ranks E5-E9 and W1-W4)

Ages of Respondents:

The average age of higher enlisted respondents was substantially higher than their LE counterparts. HE/ADs averaged 30.9 years (SD=6.2) and HE/FMs averaged 29.7 years (SD=5.8). Only 16% of HE/ADs were under 25 while 30% were between 25 and 29 and 43.67% were between 30 and 39. Another 10.67% were 40 or over. For HE/FMs, 21.95% were under 25, 29.88% between 25 and 29, 42.07% between 30 and 39, and 6.1% 40 or over.

Time in Military Service:

The HE/ADs in the sample had also been in the army substantially longer than the LE/ADs averaging 10.2 years ($SD=5.3$). Only 2.84% had been in three years or less and only 21.28% had been in 5 years or less. This means that 78.72% have been in 6 years or more with 39.01% having been in more than 10 years. Years of service were even higher for HE/FMs which averaged 11.4 years ($SD=5.8$) with 85% having been in 6 years or more and 47.14% having been in more than 10 years.

Marital Status:

Most HE/ADs are married (79.33%) and almost all HE/FMs are (97.04%). Substantially more HE/ADs are married than are LE/ADs while the percentage of FMs for both groups are roughly the same. Those HE/FMs that are not married are either divorced, separated, or widowed from an HE/AD, or are the child of an HE/AD.

Length of Marriage:

The average length of marriage for HE/ADs was 7.7 years ($SD=5.7$). Roughly a quarter of the HE/ADs had been married 3 years or less (25.78%) but few were married 1 year or less (7.81%). Most were married substantially longer with 22.66% having been married 4 or 5 years, 23.44% having been married 6 to 10 years, and 28.12% having been married more than 10 years. Among the HE/FMs, the average length of marriage was 7.9 years ($SD=5.1$) with 18.79% having been married 3 years or less, 18.18% having been married 4 or 5 years, 34.55% having been married 6 to 10 years, and 28.49% having been married over 10 years. Thus, on the average, HE respondents had been married substantially longer than LEs.

Number of Children:

Of the HE/ADs interviewed, including those not married, only 27.33% reported no children in their home with 5.64% reported one to two children and 17.34% reported 3 or more children. The average number of children reported by HE/ADs was 1.4 ($SD=1.1$). Only 8.88% of the HE/FMs reported no children at home. Most (67.46%) reported one or two children while the remainder (23.67%) reported 3 or more with the average number of children being 1.9 ($SD=1.2$). HE families are more likely to have children present and more likely to have larger numbers of children than are LE families. However, most HE/AD families still only have 1 or 2 children.

Age of Youngest Child:

The average age of the youngest child for HE/ADs was 5.3 ($SD=4.7$) with 33.04% reporting a child under 3 years old while 22.22% reported their youngest child as being between 3 and 5 inclusive. Another 34.26% report their youngest child as between 6 and 12 inclusive with only 5.48% reporting their youngest child as being over 12. For HE/FMs, the average age of the youngest child was 5.4 ($SD=4.4$) with 31.12% having at

least one child at home under 3, 29.22% reporting their youngest child as between 3 and 5, 26.62% reporting their youngest as between 6 and 12, and 11.04% with their youngest over 12. While a large number of HE families have children under 3, they are much less likely to do so than are LE families and are much more likely have their youngest be 6 or over.

Age of Oldest Child:

For HE/ADs, the average age of their oldest child was 8.7 (SD=6.0). While 21.3% of HE/ADs report their oldest child as being under 3 and another 15.74% report their oldest as between 3 and 5, the largest portion (62.41%) have at least one child 6 or over with 30.5% reporting their oldest child as between 6 and 12, 27.28% reporting their oldest as between 13 and 18, and 4.63% reporting their oldest as over 18. These figures are similar to those for HE/FMs where the average age of the oldest child was 8.6 (SD=5.0) with only 9.74% report having their oldest under 3, 21.43% between 3 and 5, 43.51% between 6 and 12, and 25.33% reporting children 13 or over. HE families are much more likely to have older children present (6 or over) than are LE families.

Education:

Only 2.68% of HE/ADs have less than a high school education with 46.98% having completed high school. Another 39.60 percent report having some college and 10.73% have attended long enough to have at least completed college making the average number of years of education for HE/ADs 13.1 (SD=1.5). For the HE/FMs, 7.23% have failed to finish high school while 63.25% have only a high school education. However, 27.11% have attended at least some college and 2.40% have attended long enough to receive a degree. The average number of years of education for HE/FMs was 12.4 (SD=1.2). Both HE/ADs and HE/FMs have higher education levels than their counter parts among the LE.

Employment Status of Non-AD Spouse:

For HE/ADs, 43.69% report having a spouse who works which is close to the figure for HE/FMs who report being employed (44.51%). While the first figure is comparable to that reported by LE/ADs, the latter figure is much higher than that for LE/FMs.

Housing:

Just over a third (34.31%) of HE/ADs report living on post while 42.03% of the HE/FMs do so. Interestingly, the former percentage is slightly lower than for LE/ADs while the latter is sharply higher than that for LE/FMs.

Active Duty Spouse:

Only 19.42% of HE/ADs report having an active duty spouse which is slightly less than that reported by LE/ADs.

Officers (Ranks O1-O10)

Ages of Respondents:

The AD officers in the sample were fairly similar in ages to the HE/ADs with the average age being 31.8 (SD=6.9). Only 6.25% of AD officers were under 25, while 43.75% were between 25 and 29. Of the remainder, 31.25% were between 30 and 39 and 18.75% were 40 or over. Among the FMs of officers, the average age was 30.4 (SD=6.4) with 18.74% under 25, 34.38% between 25 and 29, 37.5% between 30 and 39, and 9.38% 40 or over.

Time in Military Service:

While the length of time the AD officers in this sample have been in the military is varied, most have been in for several years. The average number of years served by AD officers was 10.3 (SD=7.3) with only 18.75% having been in three years or less, but 37.5% having been in 5 years or less. Another 39.29% have been in 6 to 10 years inclusive while a large percentage (43.75%) have been in more than ten years. For FMs of officers, the average length of time in the service was 10.4 years (SD=6.7) with 25% having been in three years or less which increases only to 28.57% for those in 5 years or less. The largest group (71.43%) have been in more than 5 years with 39.29% having been in 6 to 10 years and 32.14% more than ten years. Officers, then, have been in substantially longer than LEs, and have somewhat similar lengths of service as HEs.

Marital Status:

Most AD officers (76.47%) and all FMs of officers were married. Once again these percentages are close to those for HEs.

Length of Marriage:

Among AD officers, the average length of marriage was 7.1 years (SD=6.1) with 28.57% having been married 3 years or less and 21.43% having been married 1 year or less. While another 21.43% were married 4 or 5 years, half were married more than 5 years with 21.43% being married 6 to 10 years and 28.57% being married more than 10 years. For FMs of officers, the average length of marriage was 8.3 years (SD=5.8) with 25.81% having been married 3 years or less, while only 3.23% had been married one year or less. Another 12.9% had been married 4 or 5 years while 32.26% and 29.04% had been married 6 to 10 years and more than 10 years respectively. Again, these figures are similar to those reported by HEs.

Number of Children:

Of the AD officers interviewed, including those not married, 52.94% reported having no children, 35.29% reported one or two children, and 11.76% 3 or more children with the average number of children reported by AD officers being .8

(SD=1.1). For the FMs of officers, 24.24% had no children, 60.61% had one or two, and 15.15% had 3 or more yielding an average of 1.4 children (SD=1.0). In this case, the numbers for officers are most similar to those of the LE which have fewer children than the HE.

Age of Youngest Child:

Most AD officers (62.5%) had at least one child at home under 6 and 37.5% had one under 3. Another 12.5% reported their youngest child as being between 6 and 12 inclusive and 25% reported their youngest child as 13 or over. The average of the youngest child reported by AD officers was 6.6 years (SD=6.2). Among FMs of officers, 72% have a child under 6 and 44% have one under 3. For the remainder, 24% report their youngest child as between 6 and 12 and only 4% report their youngest as over 12 producing an average age of 4.4 (SD=4.3) for the youngest child of FMs of officers. The youngest children of officers are not quite as young as those of LE, and are most similar in age to those of the HE.

Age of Oldest Child:

The average age of the oldest child reported by AD officers is 8.6 (SD=6.5). A quarter (25%) of AD officers report their oldest child as being under 3 and another quarter (25%) report their oldest child as being between 3 and 5 inclusive. While only 12.5% have an oldest child between 6 and 12, 37.5% claim their oldest is over 12. The average age of oldest children of FMs of officers is 7.3 (SD=5.6) with ages being distributed slightly differently from the ADs. Only 16% report their oldest child under 3, but 36% report their oldest as between 3 and 5 inclusive. Another 24% report their oldest as between 6 and 12, and 24% report the oldest as over 12. These figures are, again, similar to those reported by HES.

Education:

The education level of AD officers is quite high with over 75% having completed 4 or more years of college and 25% having some graduate training making the average number of years of education quite high at 16.4 (SD=.4). Among FMs of officers, the level is lower, but still higher than among other FMs with 21.21% having finished high school, 27.27% having some college, 39.39% having four years of college, and 12.12% having more than four years of college. The average for FMs of officers is 14.8 (SD=2.). The education level of officers is substantially higher than for LEs or HES.

Employment Status of Non-AD Spouse:

A large majority (80%) of AD officers report having spouses who work. However, only 34.38% of FMs of ADs claim to be employed. This discrepancy is even more dramatic than that noted among the LE and further suggests that working FMs may be less likely to use military health care. While the percentage of AD officers reporting working spouses is substantially higher than that reported by other ADs, the

percentage of FMs of officers claiming to be employed falls between that reported by LE/FMs and HE/FMs.

Housing:

Almost all AD officers in this sample (93.75%) live off post and 86.21% of FMs of officers make the same claim making officers much less likely to live on post than either LEs or HEs.

Active Duty Spouse:

Only 7.14% of AD officers report having an AD spouse. This figure is lower than that reported by other ADs.

Composite Summary

Lower enlisted persons and their families are relatively young. Most of the adults are under 25 with the average age being 22.5, and where children are present, most are under 3 with the average age of the oldest child being around 3.5. In this sample, about half of the ADs at this rank were married as were all the FMs. Yet most had been married less than 3 years and many less 1 year. The average length of marriage was about 2.5 years. Between 65% and 75% of those married have children, but very few have more than two. The average number of children being slightly more than 1. Most respondents at this rank had finished high school and approximately a quarter had some college with the average number of years of education completed being just over 12. However, a fifth of the FMs had less than a high school education. While 45% of married ADs reported spouses who worked, only 27% of the FMs interviewed claimed to work suggesting that FMs who work may be less likely to use military health care. A similar pattern was found among officers, but not among the higher enlisted. In addition, 28% of ADs reported AD spouses. Finally, while over 40% of AD respondents at these ranks live on post, only around a quarter of FMs do. This suggests that married persons are less likely to live on base. This is borne out by figures that show 57% of single ADs in the over all sample live on post while only 26% of married ADs report doing so.

Higher enlisted persons and their families are much older. Most adults at these ranks are between 25 and 39 with the average age being just over 30. Children in these families are also older with ages ranging from under 3 to over 13, but most falling between 6 and 12 years old. The average of youngest children in these families is just over 5.5 while the average age of oldest children is around 8.5. A much larger percentage (almost 80%) of ADs at this rank are married and, again, almost all FMs are. In addition, higher enlisted persons have generally been married much longer than lower enlisted with well over half having been married at least 6 years and the average length of a marriage being about 7.8 years. Higher enlisted families are also more

likely to have children at home and are more likely to have more children with around 20% reporting 3 or more children and the average number of children approaching 2. Higher enlisted families are also better educated with more ADs having at least some college (averaging 13 years of education) and fewer FMs having failed to finish high school. Spouses in higher enlisted families are more likely to be employed than are spouses in lower enlisted families, and in this case, ADs and FMs agree as to the percentage of spouses working. Also, the higher enlisted FMs interviewed are more likely to live on post than are their lower enlisted counterparts. To conclude this section, about 20% of higher enlisted ADs report having AD spouses.

Officer families also tend to be older. Most officers and officer FMs (75% and 71% respectively) were between 25 and 39 with average ages being around 31. The ages of children for officers and officer FMs varied with between 65% and 75% having at least one child under 6 while roughly 50% have at least one child 6 or over. The average age of oldest children was between 7 and 9 years while the average age of youngest children was between 4 and 7. Thus, the ages of officers children were more evenly distributed than those of enlisted families. Like the higher enlisted, most officers were married (76%) and all FMs of officers were. Yet more officers had been married for less than 3 years with 29% of ADs and 26% of FMs falling in this category. However, at least half of ADs and FMs had been married more than 5 years and around 30% had been married more than 10 years. The average length of an officer marriage was about 7.5 years. More officer families report having no children than did higher enlisted families, and slightly fewer report having 3 or more children making the average number of children about 1. Officers families had much higher education levels with all ADs having at least four years of college and 51% of FMs having at least that much. The average number of years of education was over 14.8 for FMs and 16.4 for ADs. While 80% of the ADs claimed to have spouses who worked, only a third of the FMs reported being employed. This is similar to the situation with the lower enlisted only much more dramatic. Almost no AD officers had AD spouses and very few officer families lived on post.

Summary Tables for ADs and (FMs)

Variable	Officers	Lower Enlisted	Higher Enlisted
Age	31.8 (30.4)	22.5 (23.2)	30.9 (29.7)
Years of service	10.3 (10.4)	2.8 (3.3)	10.2 (11.4)
Years of marriage	7.1 (8.3)	2.2 (3.0)	7.7 (7.9)
# of children	.8 (1.4)	.5 (1.2)	1.4 (1.9)
Age of youngest	6.6 (4.4)	2.2 (2.2)	5.3 (5.4)
Age of oldest	8.6 (7.3)	3.3 (3.8)	8.7 (8.6)
Years of ed.	16.4 (14.8)	12.5 (12.0)	13.1 (12.4)
% married	76.5 (100)	52.0 (100)	79.3 (97.0)
% on post	6.3 (13.8)	42.7 (24.4)	34.3 (42.0)
% employed	80.0 (34.4)	45.2 (27.4)	43.7 (44.5)
% AD spouse	7.1	28.3	19.4

Cell Count Frequencies by Rank, Marital Status and Children for ADs and FMs

	Officers		Lower Enlisted		Higher Enlisted	
	AD	FM	AD	FM	AD	FM
Married with children	8	25	45	92	95	151
Married, no children	5	8	46	33	24	13
Not married with children	0	0	15	0	14	3
Not married, no children	4	0	69	0	17	2
<hr/>						
Total	17	33	165	125	150	169

June 20, 1989

Means and Standard Deviations of Family Life Course Variables
by Respondents Status, Family Composition, and Rank.
(Percentages provided for select variables.)

Active duty, married, with children (N=152).

	Officer (N=8)	Lower Enl. (N=45)	Higher Enl. (N=95)
Age	34.9 (7.5)	22.7 (3.1)	31.5 (6.2)
Years of service	11.9 (8.9)	3.2 (2.4)	10.3 (5.4)
Years married	7.4 (4.6)	2.2 (2.0)	8.1 (5.8)
# of children	1.8 (0.9)	1.4 (0.8)	1.9 (0.9)
Age of youngest	6.6 (6.2)	1.7 (1.3)	5.2 (4.8)
Age of oldest	8.6 (6.5)	3.1 (2.7)	8.4 (6.0)
Years of ed.	16.3 (0.8)	12.6 (1.1)	13.2 (1.6)
% on post	12.5	21.4	38.4
% working spouse	66.7	28.1	40.3
% AD spouse	0.0	22.7	18.3
% female	0.0	17.8	13.7

Active duty, married, no children (N=76).

	Officer (N=5)	Lower Enl. (N=46)	Higher Enl. (N=24)
Age	28.6 (6.4)	22.8 (2.8)	29.8 (6.4)
Years of service	8.0 (4.8)	2.4 (1.8)	9.4 (5.0)
Years married	5.2 (8.3)	1.6 (1.9)	5.8 (5.9)
Years of ed.	16.4 (0.9)	12.6 (1.3)	12.9 (1.1)
% on post	0.0	12.5	21.7
% working spouse	100.0	65.4	57.9
% AD spouse	20.0	34.9	20.8
% female	20.0	43.5	20.8

Active duty, not married, with children (N=31).

	Officer (N=0)	Lower Enl. (N=15)	Higher Enl. (N=14)
Age	-	24.0 (3.3)	30.6 (4.8)
Years of service	-	4.0 (2.3)	10.8 (3.7)
# of children	-	1.1 (0.4)	2.1 (0.9)
Age of youngest	-	3.7 (4.4)	6.3 (4.0)
Age of oldest	-	3.7 (4.4)	10.1 (5.4)
Years of ed.	-	12.7 (1.1)	13.1 (1.4)
% on post	-	21.4	25.0
% female	-	66.7	57.1

Family member, married, with children (N=276).

	Officer (N=25)	Lower Enl. (N=92)	Higher Enl. (N=151)
Age	31.8 (5.8)	24.2 (4.3)	30.0 (5.6)
Years of service	11.6 (6.5)	3.7 (2.7)	11.1 (5.4)
Years married	9.2 (5.0)	3.5 (2.4)	8.4 (5.1)
# of children	1.8 (0.8)	1.6 (0.8)	2.1 (1.1)
Age of youngest	4.4 (4.3)	2.2 (2.2)	5.4 (4.4)
Age of oldest	7.3 (5.6)	3.8 (3.5)	8.7 (5.0)
Years of ed.	15.0 (2.0)	12.0 (2.3)	12.4 (1.2)
% on post	13.6	30.5	47.5
→ % working spouse	25.0	27.5	42.5
% female	84.0	97.8	98.7

does this mean
independent
worker?

Family member, married, no children (N=55).

	Officer (N=8)	Lower Enl. (N=33) 20%	Higher Enl. (N=13) 1%
Age	26.0 (6.5)	20.6 (1.8)	28.3 (8.2)
Years of service	6.6 (6.5)	2.3 (1.4)	15.3 (8.9)
Years married	5.0 (7.6)	1.6 (1.2)	4.3 (4.0)
Years of ed.	14.0 (1.8)	12.0 (1.2)	12.3 (1.3)
% on post	14.29	9.38	0.00
% working spouse	62.50	28.13	61.54

Family member, not, married, with children (N=5).

	Officer (N=0)	Lower Enl. (N=0)	Higher Enl. (N=3)
Age	-	-	27.0 (3.0)
Years of service	-	-	15.0 (2.8)
Years married	-	-	6.7 (2.5)
# of children	-	-	1.5 (0.6)
Age of youngest	-	-	4.3 (1.5)
Age of oldest	-	-	4.3 (1.5)
Years of ed.	-	-	11.3 (1.2)
% on post	-	-	0.0
% working spouse	-	-	66.7
% female	-	-	66.7

Family member, married, with children (N=276).

	Officer (N=25)	Lower Enl. (N=92)	Higher Enl. (N=151)
Age	31.8 (5.8)	24.2 (4.3)	30.0 (5.6)
Years of service	11.6 (6.5)	3.7 (2.7)	11.1 (5.4)
Years married	9.2 (5.0)	3.5 (2.4)	8.4 (5.1)
# of children	1.8 (0.8)	1.6 (0.8)	2.1 (1.1)
Age of youngest	4.4 (4.3)	2.2 (2.2)	5.4 (4.4)
Age of oldest	7.3 (5.6)	3.8 (3.5)	8.7 (5.0)
Years of ed.	15.0 (2.0)	12.0 (2.3)	12.4 (1.2)
% on post	13.6	30.5	47.5
→ % working spouse	25.0	27.5	42.5
% female	84.0	97.8	98.7

Does this mean
dependent
wishes?

Family member, married, no children (N=55).

	Officer (N=8)	Lower Enl. (N=33) 20%	Higher Enl. (N=13) 17%
Age	26.0 (6.5)	20.6 (1.8)	28.3 (8.2)
Years of service	6.6 (6.5)	2.3 (1.4)	15.3 (8.9)
Years married	5.0 (7.6)	1.6 (1.2)	4.3 (4.0)
Years of ed.	14.0 (1.8)	12.0 (1.2)	12.3 (1.3)
% on post	14.29	9.38	0.00
% working spouse	62.50	28.13	61.54

Family member, not, married, with children (N=5).

	Officer (N=0)	Lower Enl. (N=0)	Higher Enl. (N=3)
Age	-	-	27.0 (3.0)
Years of service	-	-	15.0 (2.8)
Years married	-	-	6.7 (2.5)
# of children	-	-	1.5 (0.6)
Age of youngest	-	-	4.3 (1.5)
Age of oldest	-	-	4.3 (1.5)
Years of ed.	-	-	11.3 (1.2)
% on post	-	-	0.0
% working spouse	-	-	66.7
% female	-	-	66.7

Means and Standard-Deviations of Number and Ages of Children
by Respondents Status, Rank, and Work Status of Non-AD Spouse.

Active duty, officer (N=13).

	Working Spouse (N=8)	Non-working Spouse (N=2)	Active Duty Spouse (N=1)
Number of children	0.6 (0.7)	3.0 (0.0)	0.0 (-)
Age of youngest	8.0 (6.3)	2.5 (2.1)	-
Age of oldest	8.5 (6.6)	8.5 (6.4)	-

Active duty, lower enlisted (N=91).

	Working Spouse (N=26)	Non-working Spouse (N=32)	Active Duty Spouse (N=25)
Number of children	0.6 (1.0)	1.0 (0.9)	0.6 (0.8)
Age of youngest	2.2 (1.6)	1.6 (1.4)	1.6 (0.7)
Age of oldest	5.2 (4.0)	2.3 (1.9)	3.2 (2.7)

Active duty, higher enlisted (N=119).

	Working Spouse (N=42)	Non-working Spouse (N=51)	Active Duty Spouse (N=22)
Number of children	1.6 (1.2)	1.5 (1.0)	1.2 (1.0)
Age of youngest	6.8 (4.2)	4.8 (5.5)	3.8 (3.2)
Age of oldest	10.9 (5.7)	7.8 (6.3)	6.4 (5.2)

A Comparison of Two Clinics: Winn Emergency Room and Primus**Part A. Clinics as major entry ways into local Army Health Care System:**

An initial focus of client data analysis has been a comparison of two sites: the Winn emergency room and Primus. The emergency room professional staff and the Winn administrative staff are familiar with a basic structural problem: the ER is the main source of non-appointed entry to health care at Ft. Stewart. One administrative response has been to create walk-in slots in the Pediatrics clinic each weekday morning and most afternoons. There are a few other walk-in slots for dependents at other clinics, but the Pediatrics slots are the most significant. The Primus clinic is readily available, but the 45-minute drive to Savannah deters travel.

The field notes of the client interviewers point to some dimensions of the access issue:

"Everyone in this clinic [Pediatrics] complaining about the difficulty in getting appointments... Several mentioned that they wind up taking their babies to the Emergency Room and some said they usually go to Primus if they can't get an appointment." (April 7)

"An awful lot of complaining about the appointment system in this clinic [Pediatrics]... One couple told me they had to wait three weeks to get an appointment... they were told they should go to the emergency room. They said they didn't think the emergency room gave very good care...[They apparently left before their appointment was called.]" (May 6)

"Saw the couple who walked out of Peds. yesterday over here [Primus] today." (May 7)

"Spoke to an AD couple who just had a baby by C-section and wife got infection in incision. Dressing needs to be changed every day, and they come to ER to have it done. Husband says they have advised him that he should be dressing it himself at home but...he has no idea what it should look like from day to day so he is uncomfortable with that..." (September 17)

These observations raise a number of questions about ease of access to health care and patterns of use of different clinics. Who uses the emergency room? How do they differ from those who

use Primus? What happens in typical encounters with providers? Is use of the emergency room related to too-low levels of self-care or an unwillingness to take responsibility for one's own health? What are the implications of the observed and reported heavy reliance on the emergency room as a source of walk-in health care?

We have not yet addressed all these issues, but have begun work on an enumerative comparison of the ER and Primus. As noted earlier, they are not the exclusive sources of primary non-appointed care, but they are the two major ones. The analysis suggests some of the effects of the structural dependence on Primus and the ER as major entry points.

The population that uses the two clinics overlaps, but there is a distinct group that uses the Winn ER, another group that uses both, and a third group that has used only Primus. Evidence comes from the analysis of the other clinics that have been used by families that report they have used Primus or the Winn ER (see Table One, Document 7a). The first line of the table includes respondents who report they have used Primus. The entries along the row indicate the proportion of the 316 Primus users who have used the other clinics: Forty-three percent have used the Winn ER. The client visit distribution among other clinics reveals that about half have used Tuttle, indicating they are most likely stationed at Hunter AAF. About half have used civilian care, perhaps reflecting the great diversity of the population with DEERS eligibility within the Savannah area.

The second line of the table (#1) reports on users of the Winn ER. Twenty-eight percent have used Primus. These families are less likely to use civilian facilities, and are clearly concentrated at Ft. Stewart.

The critical data concern the crossover between Primus and the Winn ER. The pattern is clearest if the percentages are turned into actual numbers: of the 674 respondents who used either Winn ER or Primus, 136 used both, 358 used Winn only, and 180 used Primus only. Aside from emergency care, Winn ER and Primus appear to provide the same type service for distinct groups at different locations.

Part B. Clinic User Characteristics in Light of Life Course Variables:

One way to look at the characteristics of the users of the two clinics is to examine regressions of clinic use on life course variables. The data reported in Table Two (Document 7b) are OLS regression estimates of a linear probability model for clinic use. The dependent variable is coded one if the respondent reports family use of the clinic and zero otherwise. While linear probability models are not strictly appropriate for binary dependent variables, they are easily interpretable and in virtually all cases lead to the same conclusion as the more-appropriate logit estimation.

The effect of any variable in a linear probability model is the predicted effect of a one unit increment in the variable on the probability of occurrence of the dependent variable. For example, in Table Two, the first column shows a coefficient for "married" of .119. Persons who are married are predicted to be 11.9% more likely to use civilian care than those who are not married. Since the estimates are based on a sample, it is important to distinguish between real effects and "noise" -- i.e. random variation in samples. A standard way to accomplish this task is by using a significance level of .05. Those coefficients that reach the .05 level are marked with an asterisk. If the true effect of marital status on use of civilian care use were zero, we would expect to observe a coefficient of .119 or larger in one of every twenty samples from the population. Coefficients that are not marked with an asterisk are not large enough to conclude that they are different from zero.

The predictor variables in Table Two are: two contrasts with higher enlisted ranks (i.e. E5 and above). "Officer" is the difference between officers and higher enlisted, and "Lower Enlisted" is the difference between lower and higher enlisted. "Married" is the difference between married and non-married persons. "Child under 6" is the difference between those who have a child under 6 in the household and those who do not. The "Family Member" variable is the contrast between family-member and active duty respondents. (NOTE: The question about clinic use asks about use by any family member. Finally, "Education" is number of years of schooling of the respondent, in years.

While the table reports on use of four different sites, we are interested in two: Primus and Winn ER. Both are used by married respondents more than non-married. Though the non-married group includes some single-parent households, it is mostly composed of single soldiers who use the TMC for care (though in this study they were interviewed in a clinic regularly used by dependents).

There are some important differences in the groups that use the two clinics: those with small children are as likely to use the Winn ER as are those with less education. Each additional year of education reduces the probability of using the Winn ER by five percent. It is not rank, but variability in schooling that occurs within ranks that determines ER use. The predicted difference in use between a college and high school graduate is 20 percent. The finding for small children in the household probably reflects the distance between Hinesville and Savannah. Families with a small ill child may not want to drive 45 minutes for medical care, while adults may prefer the drive to a long wait in the ER.

Rank predicts use of Primus. Officers are 28 percent more likely to use Primus than are higher enlisted families; lower enlisted families are 12 percent less likely than higher enlisted to use Primus. Further analysis is needed to establish whether this effect is due to the distribution of ranks at Hunter AAF.

At the moment, it appears that higher rank-- meaning more experience in the army and greater knowledge, skill, and resources that are useful in effectively utilizing army medical facilities-- lead families to Primus.

The lower education of those who use the ER, compared to all persons who were interviewed, may suggest inappropriate use by those unwilling to engage in self-care or those unable to manage access to a more appropriate clinic. Since higher education is not associated with greater use of Primus or the other Winn medical clinics, it appears those of lower education use the ER in addition to other clinics.

Part C: Selected behavioral experiences in ER and Primus utilization:

The implications of the use of the emergency room is suggested in Table Three. (Document #7c) Table Three reports OLS regressions, using questions about "what happens to you in this clinic." While everyone, regardless of the clinic in which they were interviewed, was asked which clinics they had used, these questions were asked in reference to the clinic of the particular interview, and were only asked of those who had used the clinic before. The questions are:

"At this clinic, how often..."

Clinques: "do you feel encouraged to ask questions?"

Clinread: "are you told where you can read something about your condition?"

Clinpic: "does the doctor or nurse use a model or diagram to help you picture what's happening?"

Clinself: "are you told what you can do to help yourself?"

Clinfull: "do you get a full, common-sense explanation?"

Clinopin: "does the doctor take your opinions about your own health seriously?"

The answers are coded on a scale of one to five in which one indicates "always" and five indicates "never." The independent variables are the ones discussed above to measure the family life course as well as a set of contrasts between Primus and the other clinics in which interviews were conducted. The analysis is reported in Table Three. It is a preliminary one since it treats the dependent variables as independent though they are asked of the same persons and cover similar topics.

In general, there are no patterns to the effect of the life course variables. However, most relevant to the topic of this discussion is the difference between Primus and the Winn ER. At the ER, respondents report less likelihood that they are encouraged to ask questions or given a full explanation, compared to reports of what happens at Primus. Though the difference between Primus and the ER is not significant for most questions, it may be that the characteristics of the ER lead to less satisfactory encounters between providers and patients.

Putting together field observations and the preliminary survey analysis, the conclusion is clear, but tentative. The structural characteristic of Ft. Stewart is that non-appointed care is available from two primary sources, ER and Primus, which are separated by a 45-minute automobile ride. As a result of distance, servicing different resident populations, or self-selection by patients, the two sites gather sets of clients that are, to some degree, distinct from each other. The ER draws a less sophisticated population with small children, and users of the ER report less emphasis on questions and explanations than at Primus.

Those of low education, who are least able to cope with self-care and access to medical care end up in the emergency room -- the most inappropriate place for non-appointed care-- in addition to using the other clinics. The overloading of the emergency room leads to less attention to patient questions. In combination, these effects produce a structurally-based problem in providing medical care.

Part D. Some Priorities for Further Analysis:

The preceding discussion suggests a number of issues related to health care that can be addressed with the patient interviews. For example, the discussion of characteristics of patients of the ER and Primus interprets education and rank as indicators of ability to use medical care. These issues can be addressed more directly, by examining questions related to sources of information, effective use of care, and self care.

These areas are:

1. Sources of Information: What are the different sources of information about health care? What are life course differences in the sources of information used? How does the pattern of sources relate to use of services and satisfaction with health care? That is, sources of information can be examined as an outcome and as a predictor.
2. Effective Use of Services: There are a number of items concerning "things you were not told," comparisons of civilian vs. military health care, and whether the active duty soldier should accompany family members to the clinic. What are patterns of variation in these responses? How are they related to the life course? To the pattern of clinic use?
3. Self care: Items on self-care can be examined as outcomes and as predictors. For example, one quote from the interviewers' fieldnotes above suggests that a couple's dissatisfaction with care received in the emergency room stemmed from the difference in definitions of appropriate self-care between them and the staff. While staff believed

the husband should change his wife's wound dressing each day, he (and perhaps she) preferred to come to the emergency room each day to have it done. Is use of the emergency room tied to low levels of self care? Is it related to relative absence of patient advice giving throughout the out-patient clinic system? Are those clients who are most dissatisfied with military health care those who expect everything will be done for them? These and similar issues can be addressed with the patient interviews.

TABLE ONE

Proportion of Persons Who Report Using Primus and Winn ER
Who Also Report Using Other Clinics

Of persons who report using	Percent who also report using						
-----	Primus N=316	Winn ER N=494	Winn MC N=542	Tuttle N=213	TMC N=260	Ft Gord N=131	Civilia N=314
Primus (N=316)		43.13	51.91	49.20	23.53	19.75	52.06
Winn ER (N=494)	27.84		83.50	11.07	47.90	18.75	38.37

TABLE TWO

Regression Estimates of the Effect of Key Life Course Variables
on Reported Clinic Usage

	Civilian N=694	Primus N=694	Winn ER N=694	Winn MC N=694
Officer	.112	.279*	.110	.079
Lower Enlisted	.027	-.121*	.007	.012
Presently Married	.119*	.135*	.231*	.097
Child under 6 in home	.025	-.055	.152*	.097*
Family member	.087*	-.023	.010	.091*
Education	.006	.016	-.051*	-.013
Intercept	.120	.096	.022	.694
R ²	.032	.083	.110	.050

* $p < .05$

Notes:

1. The sample (N=694) includes active duty and dependents of active duty only.
2. Dependent variables were coded as 1 if the respondent reported having used the clinic before and 0 if not. Coefficients represent the increased or decreased probability that a respondent used the clinic (i.e., was coded 1) if the independent variable is increased by one unit.
3. Officer and lower enlisted (E4 or less) are coding categories for rank and coefficients represent comparisons to higher enlisted. Rank is assigned to family members based rank of the active duty person on whom DEERS eligibility is based.
4. Presently married respondents were either married or living with someone at the time of the interview.
5. Child under 6 in home indicates the presence of a child 5 years or younger in the respondents household at the time of the interview.
6. Family member indicates that the respondent is a family member and not active duty.
7. Education is the number of years of education reported by respondents.
8. R² is the proportion of the total variation in clinic usage explained by the variables in the model.
9. $P < .05$ means that the probability of finding a difference in probability as great as that indicated that is due to random error is only five percent.

TABLE THREE

Regression Estimates of the Effect of Key Life Course Variables on Clinic Evaluation Questions Controlling for Clinic Where Interview Took Place

	Clinques N=575	Clinread N=557	Clinpic N=555	Clinself N=568	Clinfull N=565	Clinopin N=540
Officer	-.290	-.402	-.661*	-.173	-.130	-.227
Lower Enlisted	.043	.111	.246*	-.032	.146	.130
Married	-.295	-.006	-.115	-.210	-.160	-.411*
Child under 6	.085	-.120	.082	-.017	.142	.216
Family member	.028	-.126	.139	.181	.148	.017
Education	.002	.059	.085*	-.023	.020	-.019
Dentac	-.495*	-.556*	-1.220*	-.631*	-.486*	-.068
Winn ER	.517*	.122	-.1170	.156	.577*	.643*
Family Practice	.143	-.135	-.493*	-.243	.122	-.003
OB/GYN	-.004	-.695*	-.372	.153	.364	.547*
Outpatient clinic	.185	-.537	-.1960	.277	.657	.845
Pediatrics	.156	.070	-.084	.331	.364	.247
Tuttle	-.045	-.067	-.487*	-.036	.284	.364
Intercept	2.672	3.438	3.030	2.611	1.844	2.686
R ²	.053	.067	.099	.064	.077	.077
F-value	5.979*	6.413*	8.421*	5.030*	7.382*	5.597*

* p < .05

Notes:

1. The sample includes active duty and dependents of active duty only. Differences in sample sizes result from missing responses on dependent variables.
2. The dependent variables are responses to a series of questions evaluating various practices of the clinics and answers ranged from 1=always to 5=never.
3. See notes 3 through 7 in TABLE TWO for an explanation of the first six independent variables.
4. The clinic variables are the clinic in which the interview took place and to which the practice evaluation questions are addressed. Coefficients represent comparisons to Primus.
5. R² is the proportion of the total variation in the dependent variable explained by the variables in the model.
6. The F-value is a test statistic measuring the overall effect of the clinic variables on the dependent variable.
7. P < .05 means that the probability of finding a value as great as that indicated that is due to random error is only five percent.

DEVELOPMENT OF THE THEMATIC AND MECHANICAL CONVENTIONS

The development of the coding procedure for the open-ended interview questions is based on processes of data reduction and thematic derivation outlined by Krippendorff and von Mering and reviewed in the Interim Report. The most recent progress in applying this procedure includes the finalization of the thematic categories derived from the responses and the development of conventions which will be used to correlate the content of a question with the established thematic categories.

In developing the coding design and procedure we defined both mechanical and thematic conventions. The development of these conventions included defining the specific issues which are represented by the questions and responses. The final issues derived from the primary interview data were then outlined and numbered.

In this outline (Document #8a) there are four major themes. Included under each of these themes are a series of subthemes, identifiers, and specifiers. The subthemes represent issues within the theme and are marked with a capital letter. Under each subtheme there is a series of identifiers which are specific subissues relating to the subtheme and theme. The specifiers represent circumstances, conditions, and/or events under which the issues presented in the subtheme arise.

The mechanical conventions represent the thematic content of the responses and will be entered into the computer. They are designed to correspond to the number or letter of the themes, identifiers and specifiers on the categorical outline. For example, if a question elicits responses related to sources of information used for self care it will be coded under theme I, subtheme A of the outline (Document #8a) and the conventions entered into the computer would be I and A.

Two documents, The Dictionary of Terms (Document #9) and the Guide of Coding Conventions (Document #10) are being drafted which provide specific parameters of meaning of the thematic issues to be coded and also explicit instructions for the interpretation of the responses and assignment of a coding convention.

DATA ENTRY USING R-BASE COMPUTER APPLICATION

The mechanical codes assigned to the content of open-ended responses by the coder will be entered directly into a computer terminal. We will be designing a screen format using R-Base, a database management system, which will prompt the coder to enter the appropriate data for each question. See Document #8b for a preliminary draft of what the screen format will be. Training on R-Base and the development of this application is expected to start in August and to continue throughout the Fall.

INTERPRETATION AND ANALYSIS OF QUALITATIVE DATA

The coding procedure is designed to produce coded data which will be interpreted both by question and also in conjunction with the other questions coded for the same theme and subtheme. In this way we will be able to interpret the data in several different ways. For example, we will be able to run frequencies for each question providing us with detailed information concerning how Army families care for themselves and how they use and perceive the Army medical system. We will also combine the analysis of several questions to reflect broader trends relating to the four major themes (see Document #8c).

Of great importance in the analysis of this qualitative data will be merging it with the quantitative data file. In this way we will be able to correlate the coded responses of the open-ended questions with the respondents' status, family type, sex, and depth of knowledge of the Army medical system as well as the clinic in which the interview was conducted. Statistical analysis, including Chi square tests, will be run to show correlations of levels of satisfaction and health care practices and behaviors with various sectors of the Army population and clinic users. Specifically, this analysis will address issues of self care, sources of information, and effective use of care which are central for the quantitative interpretation (see Document #7).

I SELF/NOT SELF CARE/SELF EFFICACY ORIENTATION

A. Sources of Communication/Information for Taking Health Seeking Action

Identifiers:

1. Informal channels of the army system
2. Formal channels of the army system
3. External of the army system
4. Personal Resources

B. Expectancies of Competence for Self/Not Self Care

Identifiers:

5. Self-perceived potential for giving and receiving self-care
6. Opportunity/Limitations for giving and receiving self care

C. Remediative Action Taking and Seeking

Identifiers:

7. Informal channels of the army system
8. Formal channels of the army system
9. Independent action
- 10 . Civilian medical professionals
11. Unspecified

Specifiers for Theme I:

1. Prevention
2. Treatment
3. Awareness
4. Emergency
5. Pregnancy/childbirth/infant care
6. Diagnosis
7. Prescription/medicine
8. Intensity
9. Duration
10. Chronic

II OPPORTUNITIES/LIMITATIONS IN TREATMENT/SERVICE
[Outcome Expectancies of Health Service Delivery]

A. Therapeutic Effort

Identifiers:

1. Triage
2. Examination
3. Diagnosis/screening
4. Treatment
5. Prognosis
6. Explanation/care counsel and advice
7. Continuity of care
8. Referral
9. Pharmacy
10. Prescription of medicinal drugs
11. Other

B. Interpersonal Handling

Identifiers:

12. Scheduling
13. Reception
14. Personal interaction
15. Information access
16. Clinic environment
17. Record keeping
18. Other

C. Organizational Efficacy

Identifiers:

19. Appointment system
20. Readiness
21. Clinic Accessibility
22. Allocation of medical resources
23. Quantity of medical personnel and services
24. Availability of appropriate medical personnel
25. Quality of medical resources
26. Patient complaints
27. Insurance
28. Medical Benefits

III PERCEIVED INEQUALITIES IN CARE AND ACCESS TO CARE

A. Civilian Versus Military Medicine

Identifiers:

1. Cost of health care and services
2. Quality of therapeutic effort
3. Quantity of personnel and services
4. Interpersonal patient handling
5. Organizational efficacy
6. other

B. Rank and Status

Identifiers:

7. Officer vs. enlisted
8. Active duty vs. family member
9. Retiree vs. active duty

Specifiers for Theme III:

1. Access
2. Patient handling
3. Organizational hierarchy
4. Life Course

IV STRUCTURAL AND FAMILIAL SUPPORT/NON-SUPPORT OF THE ARMY FAMILY

A. Family Support

Identifiers:

1. emotional/moral support
2. transportation
3. childcare
4. guidance (language interpretation, advice, explanations)

B. Structural Support

Identifiers:

5. Army support
6. Disbelief
7. Neutral attitude
8. Doesn't know

Specifiers for Theme IV:

1. Benefits
2. Financial advantages
3. Career opportunities
4. Life course
5. Army life style
6. "Army community"

Computer Screen Prompts*

Interview Question #	Coding Questions	Possible Values
*Each question will appear on the computer screen separately.		
#6G	ID # THEME IDENTIFIERS	001-801 II 0-28
#8A	ID # THEME RESPONSE IDENTIFIERS	001-801 II 1,2 (1=yes, 2=no) 0-28
#8B	ID# RESPONSE THEME IDENTIFIER	001-801 1,2 (1=yes, 2=no) I 9-13 (only 1)
#9A	ID# THEME RESPONSE IDENTIFIER	001-801 III 1,2,3 (1=better, 2=same, 3=worse) 1-6
#10A	ID# THEME IDENTIFIER SPECIFIER FOR THEME III	001-801 III or IV 7-8 or 1-4 1-4
#16B	ID# THEME RESPONSE OF #16A IDENTIFIER SPECIFIER	001-801 I 3P 1-7
#17A	ID# THEME IDENTIFIER SPECIFIER	001-801 I 3P or 3N 1-7

#18A	ID# THEME IDENTIFIER SPECIFIER	001-801 I 3P or 3N 1-7
#19A	ID# THEME IDENTIFIER SPECIFIER	001-801 I 7P 1-7
#19B	ID# RESPONSE THEME IDENTIFIER SPECIFIER	001-801 0,1,2 (0=blank, 1=yes, 2=no) I 2P 1-7
#20A	ID# THEME IDENTIFIER SPECIFIER	001-801 I 8P 1-7
#20B	ID# THEME IDENTIFIER SPECIFIER	001-801 I 8N 8-10
#24	ID# THEME IDENTIFIER	001-801 I 1P-5P
#28	ID# RESPONSE THEME IDENTIFIER	001-801 1 or 2 (1=yes, 2=no) II 1-8
#29	ID# RESPONSE THEME IDENTIFIER	001-801 1,2,3 (1=better 2=same 3=worse) II 1-28

#30	ID# RESPONSE (1=better, 2=same, 3=worse, 4=DK) THEME IDENTIFIER SPECIFIER	001-801 1,2,3,4 I or IV 8P/8N or 5N/5P 1,3,5,7,10 or 1 or 5
#31	ID# THEME IDENTIFIERS	001-801 II 1-28
#33	ID# THEME IDENTIFIERS	001-801 IV 1-4
#37	ID# THEME IDENTIFIER SPECIFIER	001-801 IV 5P or 5N 5
#38	ID# THEME IDENTIFIER	001-801 IV 5P,5N, 6-8 (only one)
#39	ID# THEME IDENTIFIER SPECIFIERS:	001-801 IV 5P 1) 1-6 2) 1-6 3) 1-6
#40	ID# THEME IDENTIFIER SPECIFIERS (only if id. as 5P)	001-801 IV 5P or 5N 2,4, or 5
#41	ID# THEME IDENTIFIER SPECIFIER	001-801 III 7-8 1-4
#42	ID# THEME IDENTIFIER	001-801 III 7

SPECIFIER

1-4

#43	ID# THEME IDENTIFIER	001-801 I 10, 13P/N
#44	ID# THEME IDENTIFIER	001-801 I 10-12, 13P/N

Distribution of Questions Coded by Thematic Category*

SELF/NOT SELF CARE/ SELF EFFICACY ORIENTATION

THEME	7Na	8b	16b	17a	18a	19a	19b	20a	20b	24	30	43	44
	R	R	R	R	R		R				R	R	
Response													
A.Scen. Comm/Info													
1.informal Army	1									1			
2.informal Army	2						2			2			
3.formal external	3									3			
4.personal	4		4		4					4			
B.Expect. Competence													
5.self potential						5							
6.opport/limit for giving self care				5				6					
C.Remediative Action													
7.informal army		7											7
8.formal army		8										8	8
9.indep action		9											9
10.civilian		10											10
11.unspecified		11										11	11
SPECIFIERS													
1.prevention			1	1	1	1	1	1			1		
2.treatment			2	2	2	2	2	2					
3.awareness			3	3	3	3	3	3			3		
4.emergency			4	4	4	4	4	4					
5.preg/birth			5	5	5	5	5	5			5		
6.diagnosis			6	6	6	6	6	6					
7.prescription			7	7	7	7	7	7			7		
8.intensity									8				
9.duration									9				
10.chronic									10		10		

*Numbers on table indicate places for potential data.

PERCEIVED INEQUALITIES IN CARE AND ACCESS TO CARE

THEME	9a R	10a R	Question Number 41	42
Response				
A. Civilian vs. Military				
1. cost of care	1			
2. quality of tx effort	2			
3. quantity of personnel	3			
4. interpersonal handling	4			
5. organizational efficacy	5			
6. other	6			
B. Rank and Status				
7. officer vs. enlisted		7	7	7
8. AD vs. FM		8	8	8
9. retiree vs. AD			9	
SPECIFIERS				
1. access	1		1	1
2. organiz. hierarchy	2		2	2
3. life course	3		3	3
4. pat. handling	4		4	4

STRUCTURAL AND FAMILIAL SUPPORT/NON-SUPPORT OF THE ARMY FAMILY

THEME	10a R	39	40	Question Number 37 R	38	30 R	33
Response							
A. Family Support							
1. emotional support	1						1
2. transportation	2						2
3. childcare	3						3
4. guidance	4						4
B. Structural Support							
5. Army support		5	5	5	5	5	
6. disbelief					6		
7. neutral attitude					7		
8. doesn't know					8		
SPECIFIERS							
1. benefits		1				1	
2. financial advantages		2	2				
3. career opportunities		3					
4. life course		4	4				
5. army life style		5	5	5			5
6. "army community"		6			6		

OPPORTUNITIES/LIMITATIONS IN TREATMENT/SERVICE

THEME	6g	7Ya R	7Yb R	Question Number 8a R	29 R	31 R	28 R
Response							
A. Therapeutic Effort							
1. exam	1	1	1	1	1	1	1
2. diagnosis	2	2	2	2	2	2	2
3. treatment	3	3	3	3	3	3	3
4. prognosis	4	4	4	4	4	4	4
5. explanation	5	5	5	5	5	5	5
6. pharmacy	6	6	6	6	6	6	6
7. prescription	7	7	7	7	7	7	7
8. other	8	8	8	8	8	8	8
B. Interpersonal Handling							
9. scheduling	9	9	9	9	9	9	9
10. reception	10	10	10	10	10	10	10
11. personal interaction	11	11	11	11	11	11	11
12. information access	12	12	12	12	12	12	12
13. clinic environment	13	13	13	13	13	13	13
14. continuity of care	14	14	14	14	14	14	14
15. triage	15	15	15	15	15	15	15
16. referral	16	16	16	16	16	16	16
17. record keeping	17	17	17	17	17	17	17
18. other	18	18	18	18	18	18	18
C. Organizational Efficacy							
19. appt. system	19	19	19	19	19	19	19
20. readiness	20	20	20	20	20	20	20
21. accessibility	21	21	21	21	21	21	21
22. quantity med services	22	22	22	22	22	22	22
23. quality of med services	23	23	23	23	23	23	23
24. avail of approp. pers.	24	24	24	24	24	24	24
25. patient complaints	25	25	25	25	25	25	25
26. insurance/champus	26	26	26	26	26	26	26
27. medical benefits	27	27	27	27	27	27	27
28. allocation of services	28	28	28	28	28	28	28

DICTIONARY OF TERMS AND DEFINITIONS FOR CONTENT ANALYSIS OF THE OPEN-ENDED CLIENT INTERVIEW QUESTIONS

The following definitions are to be used as guidelines for the interpretation and coding of the WRAIR open-ended client interview questions. All the definitions are derived from the open-ended responses. The terms defined correspond with the Outline of Thematic Categories (see Document #6a). The definitions provided are written specifically as thematic coding conventions and are not intended to be definitive for any other purpose.

Please note that this dictionary is a work in-progress. Upon completion all the themes, subthemes, identifiers, and specifiers will be defined. At this time most of the identifiers and specifiers have been defined.

I SELF/NOT SELF CARE/ SELF EFFICACY ORIENTATION

A. Sources of Communication/Information for Taking Health Seeking Action

Identifiers:

1. Informal channels of the army system:

a. Social contacts made in the army but not formally representing any army unit or agency. These may include either personal relationships with friends, relatives, or co-workers as well as support groups, such as army wives support groups.

2. Formal channels of the army system:

a. Includes all units, agencies, services, and training which is organized, funded, and operated by the military. Common examples include the ACS Welcome Center, all troop and MEDDAC units, basic health care skill training, the chaplain, military newspapers and media, as well as DENTAC, MEDDAC, PRIMUS, and Hunter health care facilities and services.

3. External of the army system:

a. State or privately operated health care facilities and services, including what is commonly referred to as conventional "civilian" health care, including doctors and dentists and any publications or services which they provide.

4. Personal resources:

a. Refers to informal non-military resources for self-care information which Army families utilize. These include published references, such as medical guides and self-help books and magazines, as well as personal non-military relationships with friends and family.

B. Expectancies of Competence for Self/Not Self Care

Identifiers:

1. Self-perceived potential for giving and receiving self care:

This identifier is used to code question #19A which refers to a respondents desire to learn certain types of health care skills. The stated desire or disinterest in learning health care skills is viewed as a reflection of the respondents self-perceived interest and confidence in giving and receiving self-care in optimum circumstances.

2. opportunity/limitations in giving and receiving self care:

Refers to an individual's perception of his or her (1)ability and (2) desire to prevent, diagnose, treat, and prognosticate illness conditions. The perceived opportunities and limitations of an individual may relate to a variety of factors including the type of illness condition, its duration, intensity, as well as the individuals familiarity with the symptoms as presenting a disease condition. While the use of home care reflects a perceived opportunity for self care, the decision to seek professional care indicates a perceived limitation for self care.

C. Remediative Action

Identifiers:

1. Informal channels of the army system:

Army services and units which are not formally recognized by the military as channels for remediative action but are nonetheless available. For example, a common response is that when a person feels that they have not received adequate health care service from one Army doctor or clinic they will go to another Army doctor or clinic. Another example is when a patient calls a doctor to complain directly without pursuing formal avenues of complaint.

2. Formal channels of the army system:

Refers to the formal channels of the Army system available to clients for making complaints when they feel that they have not received service or opportunity for service. Examples of such channels include the "chain of command", the patient representative (such as Ms. Nelly Nelson at Ft. Stewart), hospital administrators, social services, as well as the health care services, such as sick call and battalion aid stations, which are designed to service clients who have immediate health needs or complaints.

3. independent action:

Refers to any remediative action that is taken on a persons own initiative using information and agents which are not related to the military or civilian health service sectors. For example, if a person is feeling uncertain about the health care that they are receiving, they may choose to research the health problem themselves and administer self-care. Other examples are the informal personal resources such as friends and relatives, as well as civilian legal or

political contacts (such as congressman) that may be mobilized when remediative action is taken.

4. Civilian medical professionals:

This refers primarily to action taken which involves the consultation with civilian doctors, nurses, dentists, and pharmacists, as well as alternative health care specialists such as chiropractors.

5. Unspecified:

Unspecified action refers to responses which indicate either remediative action or non-action but do not give specific reasons, explanations, or avenues through which action was taken.

Specifiers:

1. Prevention:

Self care employed to reduce the likelihood of illness or to improve well-being. Examples include diet, nutrition, cessation of smoking, reduction of drinking, exercise, and regular check-ups.

2. Treatment:

Includes advice and information concerning treatment procedures, home care, and home remedies for chronic and non-emergency illness and disease conditions.

3. Awareness:

Increasing knowledge and general education about wellness and illness. May refer to specific or non-specific conditions, but the intent of self care is an expansion of awareness and not any other activity, such as prevention or diagnosis.

4. Emergency:

Includes advice, diagnosis, training in the treatment of, and the treatment of acute "emergency" conditions.

5. Pregnancy/childbirth/infant care:

Refers to awareness, diagnosis, treatment, advice, prescriptions, and health care training in any issue related to pregnancy, childbirth, and infant care. Does not include childhood diseases in general.

6. Diagnosis:

May refer to self diagnosis as well as to advice and information concerning a physicians diagnosis. For example, a person may consult a friend or a medical guide to re-check a diagnosis obtained from a medical professional.

7. Prescription/medicine:

Refers to any information sought or action taken in which the primary purpose was to obtain or learn about prescription medicines, including their side-effects.

8. Intensity:

Refers to the perceived seriousness of an illness or disease condition. For example "when a condition worsens", "when really sick", and "if in pain" all refer to the intensity of an illness experience.

9. Duration:

Refers to the span of time a condition lasts. Does not refer to emergency or long-term chronic diseases, such as diabetes. Rather, the duration of an illness refers to the length of time common colds, flus, and viruses take to heal.

10. Chronic:

The diagnosis, care, and impact of long-term disease on a persons ability to care for him or herself.

II OPPORTUNITIES/LIMITATIONS IN TREATMENT/SERVICE
[Outcome Expectancies of Health Service Delivery]

A. Therapeutic Effort

Identifiers:

1. Triage:

Selection of patients to be treated first on basis of greatest medical need. Also includes routing patients to most appropriate clinic.

2. Examination:

Examining and questioning of the patient concerning their state of health and illness. Includes taking history, asking and answering questions, and examining vital signs (such as temperature and blood pressure).

3. Diagnosis/screening:

Determining the cause of an illness condition or disease. Includes the use of the army medical guide for diagnosis, laboratory testing and screening.

4. Treatment:

Referring to any treatment procedure whether for the prevention, relief, or cure of an illness or disease.

5. Prognosis:

Prediction of the outcome of a disease or illness condition.

6. Explanation/care counsel and advice:

Includes explanations relating to all aspects of the therapeutic effort including triage, examination, diagnosis, screening, treatment, prescription of medicines, referral, and the continuity of care.

7. Continuity of care:

Refers to both regularity of care and also seeing the same doctor each time a client returns to the clinic.

8. Referral:

Directing the patient to another doctor, clinic, or specialist either in the army or in the civilian sector. Includes also CHAMPUS referrals.

8. Pharmacy:

The patient's experience in obtaining drugs from military pharmacies. Includes the quality of the drugs obtained, the service received from the pharmacy staff, and the efficiency of the pharmacy in delivering appropriate pharmaceuticals.

9. Prescription of medicinal drugs:

Includes the physicians handling of the prescription of medicines to the patient. May involve prescribing the appropriate drug, explaining the side-effects of the drugs, or calling the patient with instructions or test results related to the taking of drugs.

10. other

B. Interpersonal Handling

Identifiers:

1. Scheduling:

Patient handling by the staff when scheduling appointments for the clients.

2. Reception:

Patient handling during the procedures of checking in, waiting for an appointment, and locating the examination and treatment areas.

3. Personal interaction:

The quality of interpersonal communication and staff attitude toward clients at any given time during a clinic encounter. Responses referring to the caring or lack of caring attitude as well as to staff treating patients like they are "faking it" to get off work should be coded here.

4. Information access:

5. Clinic environment:

The equipment, furnishings, and ambience of the clinic.

6. Record keeping:

Procedures and patient handling in regards to maintaining patient files, including test results, and processing required paper work, such as a profile.

7. Other:

C. Organizational Efficacy

Identifiers:

1. Appointment system:

Hospital or clinic organization of the appointment system. For example, at WINN some important issues are the centralization of the appointment system, limited number of phone lines available, and the number of conditions which will be examined during an appointment. At PRIMUS, examples of appointment system issues are that only one condition will be examined per appointment and each patient must make separate appointments each time they want a prescription refilled.

2. Readiness:

The balancing of the army's preparedness for providing war-time health care with their commitment to provide quality care to the entire army family during peacetime.

3. Clinic accessibility:

Convenience of clinic hours, clinic location, and availability of transportation to the clinic.

4. Allocation of medical resources:

privileges of different military personnel to use health care facilities. For example, health services are differentially allocated to retirees, active duty, and dependents. Differences in the allocation of resources also exist between servicepeople of certain units, as in the Family Practice and Aviation clinics.

5. Quantity of medical personnel and services:

Includes issues of adequate staffing and the overall number of hospitals and clinics available. Issues such as possible shortages of doctors and other staff, differences in the number of services available between posts, and the total number of clinics available in any geographical region are included.

6. Availability of appropriate medical personnel:

Availability of specialists and specialty clinics, substitution of physicians assistants for doctors, and being able to choose one's own doctor.

7. Quality of medical services:

Standards of health care service, training level of medical personnel, and quality of technology available.

8. Patient complaints:

Formal military channels for handling patient complaints.

9. Insurance

CHAMPUS insurance program and supplements.

10. Medical benefits:

Medical services are free to army families. An advantage of this benefit is that army families do not have to worry about medical costs and can use the system as they need. On the other hand, some military personnel feel that because health services are free, the medical system is overused and abused.

III Perceived Inequalities in Care and Access to Care

A. Civilian Versus Military Medicine

Identifiers:

1. Cost of health care and services:

Refers to the perceived relative high cost of civilian medical care and insurance compared to the free medical benefits provided by the army. Includes the perception that because civilian doctors are paid they have greater incentive to work harder, provide better services, and are more liable for their work than are military doctors.

2. Quality of therapeutic effort:

Ability and standards of the medical personnel in providing therapeutic services. May include differences in training of personnel and technology available in the military and civilian sectors.

3. Quantity of personnel and services:

Includes issues of adequate staffing and the overall number of hospitals and clinics available. Issues such as possible shortages of doctors and other staff, differences in the number of services available between posts, and the total number of clinics available in any geographical region are included.

4. Interpersonal patient handling:

Refers to the rapport established between providers, clinic staff and patients throughout the patients clinic experience. Examples of activities during which rapport is built include scheduling, reception, examination, treatment, follow-up, and record keeping. Intervening factors contributing or detracting from the ability to establish rapport, such as the clinic environment, are also included.

5. Organizational efficacy:

The institutional management of health care services including the allocation of health care resources, employment of medical personnel, operation of health care facilities, handling of patient complaints, and provision of insurance and promotion programs.

6. Other:

B. Rank and Status

Identifiers:

1. Officer vs. enlisted

2. Active duty vs. family member

3. Retiree vs. active duty

Specifiers:

1. Access:

Any inequality in the accessibility of health care for whatever reason such as shortage of doctors, assignment of clinic, and appointment system accessibility. Examples include: active duty must go to sick call and field troops must use battalion aid stations while family members may go to clinics during regular clinic hours. Generally, this specifier refers to inequalities which arise between groups in getting into a clinic as opposed to inequalities which arise after a patient is in the clinic. The latter will be specified under patient handling.

2. Patient handling

Refers to the rapport established between providers, clinic staff and patients throughout the patients clinic experience. Examples of activities during which rapport is built include scheduling, reception, examination, treatment, follow-up, and record keeping. Intervening factors contributing or detracting from the ability to establish rapport, such as the clinic environment, are also included.

3. Organizational hierarchy:

Inequality issues arising due to the fact that active duty are part of the chain of command and family members are not. This may result in either a positive or negative perception of the military bureaucracy. For example, one perception is that because active duty personnel are part of the hierarchy they are able to utilize the chain of command more effectively. On the other hand, some people perceive that the chain of command is a threat to active duty personnel and may deter them from getting as good of health care as their dependents.

Organizational hierarchy also refers to issues of readiness and/or that active duty personnel receive better care so that they can perform their job efficiently. Related to this perception is that active duty personnel should not get sick or if they do they may be perceived by their commanders and medics as "just trying to get off work."

Responses suggesting that officers are perceived as more important and valued than other personnel because of their hierarchy should also be coded here.

4. Life course

IV Structural and Familial Support/Non-Support of the Army Family

A. Family Support

Identifiers:

1. emotional/moral support
2. transportation
3. childcare
4. guidance (language interpretation, advice, explanations)

B. Structural Support

Identifiers:

1. Army support:

Refers to an attitude that the military provides benefits, services, programs, and facilities which are perceived as being either

supportive or non-supportive for army families. Use this identifier to code the presence or absence of this attitude in relation to how respondents feel about the influence of the army on their health as is presented in question #30. This identifier is also used to code questions #37, #38 and #39. In these instances, this identifier is used to mark a general attitude of support/non-support towards certain benefits and arrangements while the specific content of the response will be coded using the specifiers.

2. Disbelief:

This identifier is only used to code question #38 concerning the respondent's definition of the army community. Disbelief refers to the attitude that "although I've heard how the army has defined the image of the army community, I do not believe that it exists".

3. Neutral attitude:

Used to code question #38 concerning the "army community" when the respondent gives a concrete definition of the army community without expressing an attitude about its value to the army family as either supportive or non-supportive.

4. Doesn't know:

Use this identifier when coding question #38 concerning the "army community" and the respondent has never heard of the army community and does not know what it means.

Specifiers:

1. Benefits

May refer to benefits in general or to specific benefits such as retirement, medical, housing, and education (in terms of or a financial benefit for higher education).

2. Financial advantages:

A response may be considered to indicate a financial advantage if it identifies something to be cheaper in the army than elsewhere or that being in the army somehow cuts the cost of living, healthcare, or other expenses. Examples include answers referring to the advantage of being in the army because of the "bad economy on the outside" or because of the cost of healthcare.

3. Career opportunities:

Refers to job training, job security, promotions, and job satisfaction.

4. Life course:

5. army life style:

Refers to aspects of military life and work which are distinct from other civilian careers and lifestyles. Some of these differences include the requirements of everyday active duty life such as physical training, stresses and opportunities of travel for active duty personnel and their families, and readiness.

6. "Army community":

This refers to the image and concept of the army community as

it is presented by the army.

GUIDE OF CODING CONVENTIONS FOR CLIENT ANSWERS TO OPEN-ENDED QUESTIONS

The following guide provides detailed instructions for the coding procedure of the open-ended questions of the client interview. Included are guidelines for the interpretation of the responses and the standard conventions which will be used to code the content of the client responses. It is expected that the coder has familiarity with the Dictionary of Terms and Definitions (Document #9) which is critical for the interpretation of the responses.

Learning to code the open-ended questions is analogous to learning how to utilize computer commands for making proper entries. For example, as in utilizing computer commands and menus the coder will be instructed how to select the proper code from a set of choices. This procedure is also analogous to the diagnostic procedure in which a clinician must select a single entity based on the presence of several symptoms.

The guide is organized in sections by question number. Each section includes a general comment on the meaning of the question and how it will be interpreted, coding convention guidelines, and examples on how to assign the appropriate codes to each question. This procedure is described in detail because it will not only serve as a guide to the coder but it will also enable us to standardize the training process. Thus, this guide is as important for the trainer as for the trainee.

The questions will be coded using standard conventions which correspond to the number or letter of the thematic categories as they are presented in The Outline of Thematic Categories (see chart 1). For example, if a question elicits responses related to sources of information used for self care it will be coded under Theme I, subtheme A and the conventions entered into the computer would be I and A.

In this outline there are four major themes referred to as I, II, III, IV under which all the responses will be coded. Included under each of these themes are a series of subthemes, identifiers, and specifiers. The subthemes represent issues within the theme and are marked with a capital letter. Under each subtheme there is a series of identifiers which are specific subissues relating to the subtheme and the theme. Finally, the specifiers represent circumstances, conditions, and/or events under which the issues presented in the subthemes arise.

In all cases, a theme, subtheme, and identifier is assigned to each question. For some questions, the coder may choose between several themes and identifiers and/or select more than one subtheme and/or identifier for a question. Specifiers are used for some questions but not for all. When they are used the

coder usually has the option of selecting one or more specifiers from a designated group.

Within each section of the guide the coding conventions for each question will always be presented in the following order: RESPONSE, THEME, IDENTIFIER, SPECIFIER. The response refers to the coding of either the yes/no response of the question which precedes the open-ended question or to the responses which were quantitatively coded. The appropriate response to be coded is explained for each question.

Some questions will require an additional coding convention referred to as VALUE. The conventions used are "P" and "N". "P" refers to a positive value or the presence of a certain issue in the response. "N" refers to a negative value or lack of presence of a certain issue in the response. Although value is not always coded, if it is it is always coded with the identifier.

The coder is reminded that this guide must be used in conjunction with the Dictionary of Terms. This guide is designed to assist in the interpretation of the questions and present the mechanics of how to code the questions. Any questions which the coder has concerning the meaning of the thematic categories should be addressed in the Dictionary.

Chart I

Outline of Thematic Categories for the Coding of Client Answers to Open-Ended Questions

I SELF/NOT SELF CARE/SELF EFFICACY ORIENTATION

A. Sources of Communication/Information for Taking Health Seeking Action

IDENTIFIERS:

1. Informal channels of the Army system
2. Formal channels of the Army system
3. External of the Army system
4. Personal resources

B. Expectancies of Competence for Self/Not Self Care

IDENTIFIERS:

5. Self-perceived potential for giving and receiving self care
6. Opportunity/Limitations for giving and receiving self care

C. Remediative Action Seeking/Taking

IDENTIFIERS:

7. Informal channels of the army system

8. Formal channels of the army system
9. Independent Action
10. Civilian medical professionals
11. Unspecified

SPECIFIERS FOR THEME I:

1. Prevention
2. Treatment
3. Awareness
4. Emergency
5. Pregnancy/childbirth/infant care
6. Diagnosis
7. Prescription/medicine
8. Intensity
9. Duration
10. Chronic

II OPPORTUNITIES/LIMITATIONS IN TREATMENT/SERVICE
[Outcome Expectancies of Health Service Delivery]

A. Therapeutic Effort

IDENTIFIERS:

1. Triage
2. Examination
3. Diagnosis/screening
4. Treatment
5. Prognosis
6. Explanation/care counsel and advice
7. Continuity of care
8. Referral
9. Pharmacy
10. Prescription of medicinal drugs
11. Other

B. Interpersonal Handling

IDENTIFIERS:

12. Scheduling
13. Reception
14. Personal Interaction
15. Information Access
16. Clinic environment
17. Record keeping
18. Other

C. Organizational Efficiency

19. Appointment system
20. Readiness
21. Clinic accessibility
22. Allocation of medical resources
23. Quantity of medical personnel and services
24. Availability of appropriate medical personnel
25. Quality of medical resources
26. Patient complaints
27. Insurance
28. Medical benefits

III PERCEIVED INEQUALITIES IN CARE AND ACCESS TO CARE

A. Civilian Versus Military Medicine

IDENTIFIERS:

1. Cost of health care and services
2. Quality of therapeutic effort
3. Quantity of personnel and services
4. Interpersonal patient handling
5. Organizational efficacy
6. Other

B. Rank and Status

IDENTIFIERS:

7. Officer versus enlisted
8. Active duty versus family member
9. Retiree versus active duty

SPECIFIERS FOR THEME III:

1. Access
2. Patient handling
3. Organizational hierarchy
4. Life course

IV STRUCTURAL AND FAMILIAL SUPPORT/NON SUPPORT OF THE ARMY FAMILY

A. Family Support

IDENTIFIERS:

1. Emotional/moral support
2. Transportation
3. Childcare
4. Guidance

B. Structural Support

IDENTIFIERS:

5. Army support
6. Disbelief
7. Neutral attitude
8. Does not know

SPECIFIERS FOR THEME IV:

1. Benefits
2. Financial Advantages
3. Career opportunities
4. Life course
5. Army life style
6. "Army community"

Question # 6C: Why did you go to a civilian facility
instead of a military one?

Comment:

This question asks the respondent to identify a limitation in army medicine which caused them to seek care in the civilian sector. Respondents usually answered with a specific example of a limitation but a frequent response also is that they were CHAMPUSED out by the military. This latter response indicates that the military itself identified a limitation in the care that they are able to provide.

Coding Convention:

Use Theme II, subthemes A, B, and C, and mark appropriate identifiers in such a way as to always reflect the limitations of military medicine mentioned by respondent.

Code as many issues as presented using more than one identifier if necessary. No value needs to be placed with the identifier because this question always refers to limitation.

Use identifier C8 to indicate that a respondent CHAMPUSED out for whatever reason, regardless if it was because of their own choice or by referral by a military doctor.

RESPONSE; N/A
THEME; II A,B,C
IDENTIFIER; 0-28 (may use more than one)
SPECIFIER; N/A

Examples:

1. IIC,21
 Needed blood test for marriage and it was convenient to go there [to civilian]
2. IIA,0
 Went to a civilian doctor in Savannah for a regular check-up.

Note: Code this as absence of content because response does not provide enough information to discern any reasons why he or she went to a civilian doctor.

Question # 8A: Since you've been in the Army, have you ever
 thought a doctor forgot to tell you something
 you needed to know?

Comment:

 This question refers to limitations in military medicine,
usually concerning issues of therapeutic effort and sometimes
interpersonal handling.

Coding Convention:

 First, code the yes/no response to this question.

 Second, code responses using Theme II A,B, and C. Most
responses will probably be most appropriately coded with
subthemes A and B.

 Use identifiers 0-28 to reflect the limitation of military
medicine presented in the response. As in question 6G, no value
is used with the identifier because the code should always
reflect limitation. The coder may use as many of the identifiers
as necessary.

RESPONSE; 1=yes 2=no
THEME; IIA,B,C
IDENTIFIER; 0-28 (may use more than one)
SPECIFIER; N/A

Examples:

1. IIA,4
 Diagnose son has hyperactive and they never followed
 through. Blow it off as with everything else.

 Code this has a therapeutic effort issue. "And they never
followed through" in this case suggests that the son never
received treatment and would be coded under "treatment".

2. IIA,6
 When she was pregnant she felt they didn't tell her
 very much. She was surprised about alot of things.

Question #8B:

A. Since you've been in the Army, have you ever thought a doctor forgot to tell you something you needed to know?

B. IF YES: What did you do about the situation?

This follow-up question reflects what type of remediative action respondents take when they perceive that they have not received adequate care or counsel.

Coding Convention:

The yes/no response to #8A must be coded (yes=1 no=2) so that it is possible to identify how many people answered yes to question #8a but did not comment on #8b.

Use Theme IC, identifiers 9 thru 13 to identify the type of remediative action which was taken. Only one identifier may be used.

Identifiers 9 thru 12 are always attributed P value. Identifier 13 (unspecified) can be coded either P or N. It is coded P when the respondent says they took action but did not indicate what type of action. Identifier 13 is coded N when the person says they took no action. No action can mean either that the person did not choose to take action or that the person wanted to take action but did not see any opportunity for doing so.

No specifiers are used.

RESPONSE;	code yes/no response to 8A (yes=1 no=2)
THEME;	IC
IDENTIFIER;	9 thru 13 (only one identifier)
VALUE:	9P, 10P, 11P, 12P, 13P or 13N
SPECIFIER:	N/A

Examples:

Question # 9A:

If you were to leave the Army, do you think the medical care you would get would be better, about the same, or worse than what you get now? (coded quantitatively)

Why do you think that?

Comment:

This question addresses a comparison between military and civilian health care. The responses to the follow-up question reveal what clients perceive as the differences between civilian and military health care service.

Coding Convention:

The better, worse, or the same response given to the question must be coded using the standard quantitative code; 1=better, 2=same, and 3=worse.

The thematic content of the response should be coded under theme III A. Any or all of the identifiers 1 thru 5 may be used as needed to code the specific differences and reasons which are stated by the respondent.

It is expected that the "same" responses will lack content because the respondent does not perceive significant differences between military and civilian health care service and for this reason these responses will not be coded.

No value will be attributed to the identifiers used to code the better and worse responses. The meaning of the thematic code will be apparent when merged with the better, worse, or same response. The better/worse data will be interpreted separately after the responses are coded.

RESPONSE;	1=better, 2=same, 3=worse
THEME;	IIIA
IDENTIFIER;	1 thru 5
SPECIFIER;	N/A

Examples:

1. 2IIIA0

- A) All doctors are the same, no matter if military or civilian.
- B) Does not go to the doctor often and therefore does not know.
- C) All doctors are bad.

2. 1IIIA,2
All military doctors are bad.

3. 3IIIA,1

Military health care is free. Can not afford civilian health care.

Question # 10A: When someone in my family needs to go to the medical clinic, its for me (or my spouse) to try to get off work (duty) to go with them. (rated and coded quantitatively)

Can you tell me about why its a good idea?

Comment:

The second question elicits two issues: (1) differences in rank and status and (2) family support. Hence this question will be coded on theme IIIB (Perceived Inequalities/Rank and Status) or on theme IVA (Support of the Army Family/Family Support). One or the other of themes may be used but not both.

When coded on theme IIIB, answers are reflecting the issue that family members feel that the active duty member needs to be there with them to help them "get through the system". This always reflects a perceived inequality because it is presumed that the active duty family member has higher status and is treated better than his or her dependent family members when seeking health care.

This question can also be coded on theme IVA Family Support. Responses referring to the issue of family members providing various kinds of support such as emotional, child care, transportation etcetera are considered to reflect the presence of intrafamilial support and should be coded IVA.

Coding Conventions:

It is not necessary to code the quantitative response to the question because it will be merged after the content codes are entered.

The coder should first decide if the response will be coded using Theme IIIB or IVA.

THEME IIIB:

If theme IIIB is used then the coder may choose from identifiers 7 or 8. In most cases identifier 8 (AD vs FM) will be used. However, on occasion an issue concerning officers' rank will be mentioned in which case identifier 7 (officer vs. enlisted) may be used.

If theme IIIB is used the coder may use specifiers 1 thru 4 to indicate the specific content of the response.

RESPONSE; N/A
THEME; IIIB
IDENTIFIER; 7 or 8
SPECIFIER; 1 thru 4

THEME IVA:

If the response refers to familial support, then Theme IVA is used. Coders may choose between identifiers 1 thru 4. More than one identifier may be used if necessary.

The issues raised in the response should be adequately coded using the identifiers. No specifiers are available for this

theme.

RESPONSE; N/A
THEME; IVA
IDENTIFIER; 1 thru 4
SPECIFIER; N/A

Question # 16 A and B: Do you have some kind of medical guide at home ? (coded quantitatively)

a. IF YES: Do you remember when you last used it?

b. IF YES TO A: What was the situation?

Comment:

This question is a three part question asking about the issue of what types of health care people try to provide for themselves by using medical guides. The first part of the question was quantitatively coded and is not directly relevant to thematic coding. The other two parts, A and B, constitute the thematic content for the qualitative analysis.

While other two part questions from the interview will be coded as separate questions, 16A and B will be coded as one question. Part A will be used only for coding the response while part B will be used for the thematic coding.

Coding Convention:

Part A of the question will be used to code the response. The response should be coded either 1=yes, they remember when they last used their medical guide or 2=no, they do not remember. If a respondent gives a specific time when they last used their medical guide the coder should mark 1 (yes). There is no convention for distinguishing different periods of time which have lapsed since a respondent last used their guide. All responses to part A should be coded yes=1 or no=2.

The content of question #16 to be coded is found in the comments to part B. If there is content it is always coded on Theme IA, indicating a general issue of information sought for self care.

Identifier 4 with the value P is always used for this question to indicate the use of personal resources for seeking information.

Specifiers 1 thru 7 are used to indicate the circumstances for which the respondent seeks information. More than one specifier may be used.

RESPONSE; from 16A 1=yes if used medical guide
2=no did not remember using guide
THEME; IA (code 16B)
IDENTIFIER; 4P (must indicate positive value)
SPECIFIER; 1 thru 7 (may use more than one)

Examples:

Question # 17A: Do you ever give health care or advice to family or friends? (coded quantitatively)

A. IF YES: Can you tell me about the last time you did that?

Comment:

This question reflects what type of health care the respondent perceives him or herself to be competent to provide to others. The focus is on giving self care and information. This question complements question #18 which focuses on receiving self care and information from others.

Coding Convention:

Code the yes/no response, 1=yes and 2=no.

Theme IB is used to indicate the general issue of perceived competence for self/not self care.

Use identifier 5 with P/N value to code the content of the response. If an answer indicates a positive expectation and competence for giving self care then it should be coded 5P. On the other hand, if the respondent indicates a negative expectation for giving self care, information, and advice then the question should be coded 5N. An example of a negative expectation is when the respondent refers someone to see a doctor which indicates not self care.

Specifiers 1 thru 7 are used to indicate in what circumstances a respondent perceives him or herself as competent to give self/not self care, information, or advice. More than one specifier may be used.

RESPONSE;	1=yes, 2=no
THEME;	IB
IDENTIFIER	5P or 5N
SPECIFIER;	1 thru 7 (may use more than one)

Examples:

Question # 18A: Do you ever receive health care or advice from someone other than a medical practitioner?
(coded quantitatively)

A. IF YES: Can you tell me about the last time this happened?

Comment:

The responses to this question provide us with three types of information including what percent of the respondents receive health care from someone other than a medical practitioner, what the sources of information are, and for what situations respondents seek this information.

While the first part of this question is coded quantitatively, the second and third types of information revealed in this question will be coded qualitatively. Interestingly enough, those respondents that answered yes to this question and then said what their source of information is, almost always refer to relatives or friends. For this reason, this question has been assigned to Theme I, identifier 4 (Self Care/Personal Resources).

Coding Convention:

The yes/no response should be coded yes=1 and no=2.

Use Theme I and subtheme A to identify this question as referring to self care issues concerning sources of information for health care seeking.

Identifier 3 will most likely be used for all responses but if necessary another identifier may be selected from identifiers 1 thru 4.

Value must be marked with this identifier. It is expected that a positive value will always be marked indicating that the source of information marked with the identifier was considered by the respondent as a positive and helpful source.

Specifiers 1 thru 7 are used to indicate the situations for which the source of information was sought. More than one specifier may be used.

RESPONSE;	yes=1 no=2
THEME;	IA
IDENTIFIER;	4 (1,2,3 may be used if necessary)
SPECIFIER;	1 thru 7 (more than one may be coded)

Examples;

Question #19A: If you could learn some kind of health care skills that would help you take care of yourself and your family, what would they be?

Comment:

This answer reflects what type of health care skills the person sees themselves as potentially being competent to learn, and would be interested in learning. It does not necessarily reflect what the person expects to learn. For example, someone may be interested in getting a nurses license, but has no expectation that this will ever happen.

Coding Convention:

There is no quantitative response to code.

Always use Theme IB, identifier 5P to code this question. This identifies the general issue of perceived competence for self/not self care and the specific issue of self-perceived competence for giving and receiving self care. In this case, learning health care skills is considered to be related to giving/not giving care to one's self.

The value "P" given to the identifier is used to maintain consistency with other questions coded with this identifier. It is used to indicate that this question refers to a positive expectation of competence for self care.

Use specifiers 1 thru 7 to indicate what types of health care skills a respondent perceives to be competent to learn. In many cases most of the content of the question will be indicated by the specifier. Frequently used specifiers will probably be 5 (pregnancy/birth/infant care) and 1 (prevention).

Note: Answers that refer to continuing formal medical training (e.g. nursing or medical school) are coded for the identifier but are not specified.

RESPONSE;	N/A
THEME;	IB
IDENTIFIER;	5P
SPECIFIER;	1 thru 7

Examples;

Question # 19B: Have you ever used the medical skills you learned during your basic training? (coded quantitatively)

IF YES: Tell me about the situation.

Comment:

This question is asking under what situations the person has used self-help skills that the army has taught them. The responses to this question generally reflect the usefulness of the army training programs as a source of self/not self care information for army personnel and families. The responses also reflect in what situations the training has proved to be most helpful.

Coding Convention:

First code the response: 0=blank, 1=yes, 2=no

If the response is YES:

Answers are always coded for Theme IA, identifier 2P indicating the presence or use of formal army training for self care.

The content of the comments of the "yes" answers is coded using specifiers 1 thru 7 to indicate the situations in which the health care skills were used.

If the response is BLANK or NO:

In this case there should not be any comment or content and therefore these questions will not be coded.

The blank responses should correlate with non-active duty status of the respondent, whereas the "no" responses will be interpreted to indicate that the health care skills which the army provides have not been useful to the respondent. These correlations will be checked during the interpretation of the data after it has been coded.

RESPONSE; 0=blank, 1=yes, 2=no

IF YES:

THEME; IA
IDENTIFIER; 2P
SPECIFIER; 1 thru 7

IF BLANK OR NO:

No further coding necessary.

Question #20A: Which kinds of health problems do you take care of yourself?

Comment:

This question reflects what health problems the person takes care of her or himself rather than going to a professional health care provider. It always reflects a positive incident of self care.

Coding Convention:

There is no quantitative response to code.

Always use Theme IB, identifier 6P to indicate the general issue of a positive expectancy of competence for self/care and the specific issue of perceived opportunities for the use of self care.

Specifiers 1 thru 7 are used to code the situations for which the respondent perceives opportunity for self care. In most cases the majority of the content of the response will be coded with the specifier(s) (may use more than one). More than one specifier may be used if necessary.

RESPONSE;	N/A
THEME;	IB
IDENTIFIER;	6P
SPECIFIER;	1 thru 7 (may be more than one)

Examples:

Question #20B: At what point do you say, "I can't take care of this anymore myself, I have to seek professional help?"

Comment:

This question reflects a limitation in self care. It asks essentially at what point in the ailing-healing process do respondents perceive themselves as incompetent to care for themselves. This question focuses on the limitations of self care presented by the process of ailing and healing and not the type of illness (as does question 20A).

Coding Convention:

There is no quantitative response to code.

Use Theme I, identifier 6N to indicate a limitation in the expectancy to give self care. It is important to note that this response should always be coded to reflect the limitation presented in the response.

Specifiers 8 thru 12 are used to identify the point in the ailing-healing process at which self care becomes limited as a source of health care. Most of the content of the response will be coded using specifiers. More than one specifier may be used if necessary.

RESPONSE;	N/A
THEME;	IB
IDENTIFIER;	6N
SPECIFIER	8 thru 12 (may use more than one)

Examples:

Question #24: How did you first find out about the health
 care system at Ft. Stewart?

Comment:

 This question always reflects a positive incident of the various sources providing information (as opposed to a particular source that was unhelpful).

Coding Convention:

 There is no quantitative response to be coded.

 Use Theme IA, identifiers 1 thru 4 to indicate the source of information to which a person refers in his or her response.

 Value P must be used with the identifiers to distinguish the responses to this question as reflecting a positive source of information as opposed to other questions coded with the same identifiers.

 Specifiers are not used.

RESPONSE; N/A
THEME; IA
IDENTIFIER; 1 thru 4
VALUE; P on all identifiers
SPECIFIER: N/A

Examples:

Question #28: Were there people other than doctors and dentists that your family went to for health problems? (coded quantitatively)

IF YES: What did this person do?

Comment:

This question asks about opportunities for alternative health care. It does not address medical care in the Army per se. However, it will reflect how many (or few) people in the Army see alternative health care as a health care option. Specifically, the response refers to what type of service the alternative health care practitioner provided for the interviewee.

Coding Convention:

The yes/no response referring to the first part of this question is coded yes=1 and no=2. Presumably only those respondents who answered yes to this first part of the question should have responded to the second part of the question. Therefore coders should only continue to code the "yes" responses.

IF YES:

Use Theme IIA, identifiers 1 thru 11, to indicate the type of therapeutic effort which was given by the alternative health care provider.

It is not necessary to code value. This question always refers to a perceived opportunity of alternative health care to provide a positive therapeutic service. It does not necessarily reflect the outcome of alternative health care services obtained.

No specifiers are used.

RESPONSE; 1=yes, 2=no
THEME; IIA
IDENTIFIER; 1 thru 11 (can be more than one)
VALUE; N/A
SPECIFIER; N/A

Examples:

Question #29: Do you feel the health care you got as a child is better, worse, or the same as the health care you get now in the Army? (coded quantitatively)

Why?

Comment:

This question asks the person to compare the quality of the health care they received as a child to that provided presently by the Army. It is not necessarily a comparison of civilian and military health care because some of the respondents were in military families as children.

Some people answered this question in terms of civilian versus military, some answered it in terms of life course (e.g. I wasn't sick much as a child), others answered it in terms of technology/knowledge advances since their childhood. Some people answered it in terms of accessible medical care (e.g. I grew up in a rural area where there were no doctors).

In order to determine if the respondent is making a civilian/military comparison, this question should be merged with the quantitative response to question #26 a and b after the codes have been compiled.

Coding Convention:

It is first coded for response- better, worse, the same. "Same" answers are not coded any further because they failed to elicit content.

"Better and worse" answers are coded for content under theme II ABC, and for identifiers 1 thru 28. It is very important to examine better and worse answers separately because "better" answers imply a limitation in the army health care system and "worse" answers imply an opportunity in the army health care system.

Response- 1,2,3

Theme- II A B C

Identifiers- 1 thru 28 (can be more than one)

Question #30:

In terms of your own health, do you feel better off or worse off than most people your own age? (quantitatively coded)

Why?

Comment:

Two major issues are raised in the responses to the follow-up question "Why?". These include self care and army support. On the one hand, some respondents identify self care issues such as exercise, diet, or chronic disease which positively or negatively affect their health. On the other hand, some respondents referred to issues directly related to their Army lifestyle, such as physical training, which they perceive as affecting their health.

Please note that some answers do not fit either Theme I or IV and are not coded. Examples include: "I am healthier because I must be lucky or by the grace of God" and "Health care is better in the United States than elsewhere."

Coding Convention:

The response to the first part of the question must be coded using the following conventions used for the quantitative analysis: 1=better 2=worse 3=same 4=don't know.

Select either theme I or IV. When the respondent says they are healthy or unhealthy because of their ability/inability for self care it is coded under Theme IB. If they refer to either the positive or negative effects of Army lifestyle or benefits then use Theme IVB.

THEME IB:

Identifier 6 is always used.

Value P or N on identifier 6 is always used. P is used for opportunity for self care (e.g. I exercise and don't drink). N is used for limitation in self care (e.g. I have diabetes or I abuse drugs).

Specifiers 1 thru 7 are used to indicate the circumstances for which self care is considered a limitation or opportunity for better health. The following specifiers are most common: 1,3,5,7, and 10.

RESPONSE;	1=better 2=same 3=worse 4=don't know
THEME;	IB
IDENTIFIER;	6
VALUE;	P or N
SPECIFIER;	1 thru 7

THEME IVB:

Identifier 5 (army support) will always be used.

Value P or N is used to indicate whether the respondent perceives the Army to be a positive or negative influence on their health. P is used if the Army is perceived positively, and N if perceived negatively.

Specifiers 1 or 5 are used to indicate if it is Army benefits or Army lifestyle which is considered to exert an

influence on one's health. One or the other identifier must be chosen and not both.

RESPONSE; 1=better 2=same 3=worse 4=don't know
THEME; IVB
IDENTIFIER; 5
VALUE; P or N
SPECIFIER; 1 or 5

Example:

e.g. required p.t. in the army makes me makes me healthier) or N for non-supportive (e.g. I am overworked in the army and it has been a stress for me). This question is also specified under 1 (benefits) or 5 (army lifestyle).

Response- 1,2,3,4
Theme- I or IV
Identifier- 8P or 8N or 5P or 5N
Specifiers-1,3,5,7,10 or 1,5

Question #33: Who came with you? (quantitatively coded)

Why?

The response to the follow-up question conveys the reasons why people are accompanied to medical facilities. For the most part, the reasons given for this question relate to providing either emotional or practical support for a family member or friend. In a preliminary analysis it appears that very few respondents were accompanied in order to help them "get through the system".

By comparing the answer to this question with question #10 (which asks if a person thinks it is a good idea to have their sponsor accompany them) it is possible to compare what clients expect and perceive as desirable with what they actually do. Just by reviewing the responses to these two questions it appears that while many army dependents and sponsors feel that it is important that the sponsor go to the clinic, in fact very few clients were actually accompanied by their sponsor. This observation will be verified by comparing the quantitative and qualitative data for these questions.

Coding convention:

It is not necessary to code a response. The response to the initial question which was coded quantitatively will be merged later.

Use Theme IVA indicate positive support of the army family.

Identifiers 1 thru 4 are used to indicate the type of support given.

No value is used because this answer should always refer to a positive incidence of support.

No specifiers are used.

RESPONSE; N/A
THEME: IVA
IDENTIFIERS; 1 thru 4
VALUE; N/A
SPECIFIER; N/A

Examples:

question #37: Do you prefer living on-post or off-post?
(quantitatively coded)

Why?

The responses to the follow-up question "Why?" reflect perceived army support specifically in terms of housing. The responses to this question will be used in conjunction with other questions to evaluate the general satisfaction with services, benefits, and facilities provided by the Army for Army families.

This question will be coded with a standard theme, identifier and specifier which identify the question as being representative of Army support issues relating to army lifestyle. The only issue which will be coded differentially is if the respondent perceives living on-post as an advantage or a disadvantage.

Coding convention:

Use the quantitative code 1=on-post 2=off-post to code the response to the initial question.

Use Theme IVB, identifier 5 to correlate the question with the issue of Army support/non-support of Army families.

Value P or N is used to indicate if the person views living on base as a positive or negative/unadvantageous experience.

Specifier 5 is always marked to indicate the relationship between living on-post and Army lifestyle.

RESPONSE;	1,2 (a=onpost, 2=offpost)
THEME;	IVB
IDENTIFIER;	5
VALUE;	P or N
SPECIFIER;	5

Examples:

Question #38:

The Army talks a lot about the "Army community". What do you think that means?

Comment:

This question evoked a variety of different answers which can generally be categorized into the following types:

1. a general definition without expressing any opinion or value of the Army community
2. an expression of either positive or negative opinion about the "Army community"
3. a recognition of how the Army defines and portrays the "Army community" but a denial that it exists as such.
4. has never heard of the "Army community". Doesn't know what it is

In order to capture the quality of the respondents' answers several identifiers were designed to code this question. These identifiers include army support, disbelief, neutral attitude, and doesn't know. They are defined in the Dictionary of Terms.

The coder should note that it may be difficult to determine when a response should be coded as "negative army support" or "disbelief" since in both cases the respondent has conveyed a sense of disappointment in the army. In this case, the coder should only use "disbelief" when the respondent states that they do not believe that the army has provided what they promised in the way of an "Army community".

Coding Convention:

There is no quantitative response to code.

Use Theme IVB.

Choose one identifier from 5 thru 8.

Only identifier 5 is assigned value. Use "P" if they say something positive about the army community and "N" if they say something negative about it.

No specifiers apply.

RESPONSE;	N/A
THEME;	IVB
IDENTIFIER;	5P, 5N, 6-8 (choose only one)
VALUE;	use for identifier 5 only
SPECIFIER;	N/A

Examples:

Question #39: What do you think are the three most important things that make a person reenlist?

The content of this question are the three reasons given by the respondent. These reasons represent what the respondent considers some of the most salient and important aspects of Army benefits and lifestyle.

Coding Conventions:

There is no quantitative response to code.

Use Theme IVB, identifier 5 to indicate that the response is related to issues of how the Army supports the Army family.

Value P is used to indicate that the response always refers to a positive assessment of Army support. All responses must be coded to reflect the positive aspects of Army support structures.

Up to three specifiers must be marked to indicate the three reasons stated by the respondent. If necessary one specifier may be used more than once. For example, a respondent may give two reasons which relate to financial advantages. In this case the specifier "financial advantages" should be marked twice.

RESPONSE; N/A
THEME; IVB
IDENTIFIER; 5
VALUE; must mark P
SPECIFIER; 1 thru 6 (list up to three specifiers, may
 use same specifier more than once)

Examples:

Question #40: How important is health care in the decision
 to reenlist? Why?

Comment:

The responses to this question elicit basically 3 issues. Some people regard it as important because of the financial savings from the free medical services. Other respondents address life course issues such as medical care for children or after retirement. Some people address army lifestyle issues such as its importance to keep fit for readiness.

Coding conventions:

There is no quantitative response to code.

Use Theme IVB, identifier 5 to indicate the presence of the general issue of Army support for Army families.

Value P or N is always used. Answers which give reasons why health care may be important in a decision to re-enlist are coded 5P. Answers which state that the health care is not important in a decision to re-enlist are coded 5N.

Only 5P answers are specified. The only specifiers which relate to the question are #2 (financial advantages), #3 (life course), and #5 (army lifestyle).

RESPONSE; N/A

THEME; IVB

IDENTIFIER; 5

VALUE; P or N

SPECIFIER; 2,4, or 5 (only specified if identified a. 5P)

Examples:

Question #41: Do you feel that everyone in your family, including the AD member, gets the same quality of health care? (quantitatively coded)

Who gets better care? (quantitatively coded)

Why?

Comment:

This three part question evokes responses concerning inequalities between family members and active duty personnel. Although the response to the first question will be recorded, the qualitative content will be found in the "Why" response. The substantial portion of this content will be coded with one or two specifiers.

It is important to note that the interpretation of the coded data from this question will not be meaningful until after the qualitative codes are merged with the quantitative data file. Without the quantitative code for the second part of this question it is not clear who (the FM or AD) the respondent is referring to as receiving better care.

Coding conventions:

Code the response to the initial question using the following quantitative codes: 1=yes 2=no 3=don't know. Presumably only those respondents that answered "no" to this question should have continued to answer the follow-up questions. However, all pertinent answers should be coded.

Use theme IIIB.

For the most part, the response should correspond to identifier #2 (active duty vs. family member) but identifiers #1 and #3 may be used if necessary.

Choose up to two specifiers from 1 thru 4. Since the specifiers indicate the reasons why an equality was perceived, a substantial portion of the response will be coded with the specifiers.

RESPONSE; 1=yes 2=no 3=don't know
THEME; IIIB
IDENTIFIER- 1,2, or 3
SPECIFIER- 1 thru 4 (1 or 2)

Question #42: Do you feel there is a difference between the health care that officers receive and the health care that enlisted personnel receive?
(quantitatively coded)

IF YES: Why?

Comment:

Question #42 is the "why" prompt of the quantitative question regarding inequity in health care between officers and enlisted personnel. The response should be coded and while only the "yes" answers should have comments, all pertinent answers should be coded. Theme III, identifier 1 is used to code the general issue of inequality while the content is coded using specifiers 1 thru 4. If necessary another identifier may be used.

RESPONSE- 1,2,3 (yes, no, don't know)

THEME- IIIB

IDENTIFIER- 1 (2,3)

SPECIFIERS- 1 thru 4 (one or two)

question #43

This question addresses the remediative action issue. It is essentially a hypothetical question: "If you or your spouse were to go to the field feeling less than 100%, what would you do about it?" It does not ask what one has done in this situation, but rather what one anticipates one would do. The situation it addresses concerns enforced risk-taking and hence addresses a different situation for remediative action than in questions #8b and 44.

This question is first coded for a response (yes or no). Only the "no" answers are further coded under theme IC (Self/Not Self: Remediative Action). Answers which reflect formal army channels as a means of remediative action are coded with identifier 10 (formal army). Examples are: "get quarters", "voice it up the chain of command", "go to medic first". Other answers are coded with identifier 13 (unspecified). For example, if the person says they would go to the field anyway without taking any specified action it is coded 13N indicating no remediative action would be taken. On the other hand, if they say they would do something but do not indicate what this would be (e.g. "try not to go") this would be coded 13P indicating the respondent would take some unspecified remediative action.

RESPONSE- 1,2 (yes, no)

THEME- IC

IDENTIFIERS- 10,13P or 13N (only one)

question #44

This question, like #43, asks what remediative action a person would take (not what they have taken) when he or she feels uncertain about their health care. It is coded under theme IC (Self/Not Self: Remediative Action). All answers are coded for identifiers 9 thru 13. Only #13 is coded with value "P" or "N". Use 13P when the person says they would do something about it, but do not specify what that action would be. 13N is used when the respondent says they would take no action.

THEME-IC

IDENTIFIERS- 10 thru 12, 13P/13N (only one)

M E M O R A N D U M

TO: Dr. von Mering
 FROM: Susannah Neal
 DATE: June 13, 1989
 RE: Chronology of Provider Interviews

DATE	SITE	INTERVIEWER	# of INTERVI CONDUCT
2/24	Primus	Dr. Darrel Miller	6
3/9,10	Primus, Tuttle Aviation	Dr. von Mering Bonnie Coats Joan McTigue	8 10 7
3/22,23	WINN, Dentac	Dr. Darrel Miller Barbara Hendry Susannah Neal	12 10 10
4/13,14	WINN, Dentac	Dr. von Mering Bonnie Coats Joan McTigue	8 15 12
4/21	WINN, Dentac	Dr. Darrel Miller Barbara Hendry Susannah Neal	6 3 6
4/28	Primus, Tuttle, Aviation	Dr. John Henretta Bonnie Coats Joan McTigue	3 6 3
5/11,12	WINN, Dentac	Dr. Henretta Bonnie Coats	7 11
6/1	WINN	Dr. von Mering Dr. John Henretta Bonnie Coats Joan McTigue	5 6 6 6
6/7-9	WINN	Dr. von Mering Joan McTigue Susannah Neal	11 12 9
TOTAL			199

Summary of Projected and Completed Provider Interviews:

	<u>TABLE I</u>											
	PED	OBGYN	FP	DEN4	PRI	TUT	ER	PHA	DEN1+	WINN*	WINN**	TOTAL
Goal(Optimum)	12	16	15	36	16	33	34	11				173
75% of total (Minimum Goal)	9	12	11	27	12	25	26	8				130
Completed	11	11	14	35	17	25	16	8	3	37	22	199

+ Dental Clinic 1

* Miscellaneous WINN direct care clinics including Medical Clinic, Internal Medicine Clinic, EENT, Out-patient Clinic, Vanguard Clinic, Physical Therapy, Occupational Therapy, CSP, Surgical Clinic, and Preventive Medicine

** Miscellaneous WINN non-direct care clinics and administrative offices including ACSB, PE, HRA, SWS, Bloodbank, CMHA, DPCCM, Outpatient Records, and the Command Suite.

This table provides a summary of the planned and completed provider interviews. The optimum goal was to interview all staff, both Primary Health Care Providers (PHP) and Clinic Support Staff (CS), in each of the clinics where patients had been interviewed during Phase I. A minimum goal was set to interview at least 75% of the total staff in each clinic. This table depicts the optimum goal, the minimum goal (75%), and the number of interviews actually completed in each clinic.

In all but two cases, the 75% goal was reached or exceeded. In the case of OBGYN, we were short one interview, and in ER we were short ten. Obtaining the desired number at ER was impossible due to the short staffing of ER and consequent difficulty in scheduling time of interviews.

As noted (DEN1+, WINN*, WINN**), we conducted additional interviews at locations where the client survey had not been carried out. These additional interviews add to the overall perspective and help to even the distribution of the kinds of staff interviewed. Sixty-two additional interviews were carried out at these sites. 137 interviews were completed at the originally targeted clinics, exceeding the 75% minimum goal by 7 interviews. The additional 62 interviews conducted at other sites adds to the original maximum goal of 173 by 26 interviews, making for a total of 199 provider interviews. One additional provider interview will be scheduled for the Fall of 1989, with the DENTAC Commander, as we were not able to interview him in the

Spring due to a schedule conflict. This will bring the total number of provider interviews to 200.

The following tables provide further breakdowns of staff and clinic distributions. Table 2 (Document 13a) illustrates the breakdown of total Primary Health Care Providers (PHP) and Clinic Support Staff(CS) interviewed at each clinic site. Tables 3 (Document 13b) and 4 (Document 13c) provide further breakdowns of of PHP and CS position descriptions of staff interviewed at each site.

Total Number of PHP and CS interviews Completed in Clinic Locations

Clinic

	PRI	TUT	AVT	DEN1	DEN4	FP	PED	OBGYN	ER	PHA	WINN*	WINN**	TOTAL
PHP	16	15	3	3	32	13	8	7	14	7	27	10	156
CS	1	5	2	0	3	1	3	4	2	1	10	12	44
TOTAL	17	20	5	3	35	14	11	11	16	8	37	22	199

* Miscellaneous WINN direct care clinics including Medical Clinic, Internal Medicine Clinic, EENT, Out-patient Clinic, Vanguard Clinic, Physical Therapy, Occupational Therapy, CSP, Surgical Clinic, and Preventive Medicine.

** Miscellaneous WINN non-direct care clinics and administrative offices including ACSB, PE, HRA, SWS, Bloodbank, CMHA, DPCCM, Outpatient records, and the command suite.

Number of Primary Care Providers Interviewed in Clinic Locations

PHP	Clinic											
	PRI	TUT	AVT	PED	ER	FP	OBGYN	WINN*	WINN**	PHA	DENI	DENIV TOTAL
DR	3	2	1	4	5	5	1	5			1	13 40
THP								6				6
RN	4	1		1	2		1	2				11
ADM		1						2	7	1	1	12
NCOIC		6	1	1	1			2				11
PHA										3		3
MDASST	2											2
MDCLK								1				1
MDSPEC				1	1	8	2	2				14
MEDDIC			1									1
EMT					3							3
LPN	1				1		1	1				4
PA	5				1							6
FN4		1										1
PNP				1								1
NA							2					2
DTA											1	16 17
TECH	1	4						6	3	3		1 18
HYG												2 2
TOTAL	16	15	3	8	14	13	7	27	10	7	3	32 155

* Miscellaneous WINN direct care clinics including Medical Clinic, Internal Medicine Clinic, EENT, Out-patient Clinic, Vanguard Clinic, Physical Therapy, Occupational Therapy, CSP, Surgical Clinic, and Preventive Medicine.

** Miscellaneous WINN non-direct care clinics and administrative offices including ACSB, PE, HRA, SWS, Bloodbank, CMHA, DPCCM, Outpatient records, and the command suite.

Number of Clinic Staff Personnel Interviewed in Clinic Locations

<u>CS</u>	Clinic											
	PRI	TUT	AVT	PED	OBGYN	DENIV	ER	FP	PHA	WINN*	WINN**	TOTAL
ADM	1	1		1					1	1	3	8
NCOIC		1								3	1	5
ADMCLK		1										1
TECH		1					1			1	1	4
CLKTYP			1								1	2
RECEP/SCTY		1				2				2	1	6
DTA						1						1
MDCLK			1	2	2		1	1		3	5	15
MDSP					2							2
TOTAL	1	5	2	3	4	3	2	1	1	10	12	44

* Miscellaneous WINN direct care clinics including Medical Clinic, Internal Medicine, EENT, Out-patient Clinic, Vanguard Clinic, Physical Therapy, Occupational Therapy, CSP, Surgical Clinic, and Preventive Medicine.

** Miscellaneous WINN non-direct care clinics and administrative offices including ACSB, PE, HRA, SWS, Bloodbank, CMHA, DPCCM, Outpatient records, and the command suite.

SURVEY, PART II PRIMARY CARE PROVIDER AND
CLIENT CONTACT PERSON INTERVIEWCODEBOOK
CLOSED ENDED QUESTIONS ONLY

card: 1
column(s): 1

1. card # 1

card: 1
column(s): 2-4
variable name: IDNUM

2. three-digit interview identification number, right justified

e.g.: 1,...50,...100,...750

card: 1
column(s): 5
variable name: VERSION

3. version number of questionnaire

2, 4

card: 1
column(s): 6-11
cover sheet
variable name: DATINT

4. date of interview

Columns:

6-7:	month: 1-12, right justified (MONINT)
8-9:	day: 1-31, right justified (DAYINT)
10-11:	year: 89 (YRINT)

card: 1
column(s): 12-14
cover sheet
variable name: CLINIC

5. In which clinic was the interview done?

DEN = Dentac
ER = Emergency Room
FP = Family Practice
OBG = OB/GYN

OPC = Outpatient Clinic
PED = Pediatrics
PRI = Primus
TUT = Tuttle
AVT = Aviation Tuttle
DNH = Hunter Dentac

card: 1
column(s): 15-18
cover sheet

variable name: HRSTART

6. Time interview began (use military time)

Columns:

15 - 16: Hour: 0 - 24, right justified (HRBEG)
17 - 18: Minutes: 0 - 59, right justified (MINBEG)

Part A

card: 1
column(s): 19 - 21
question: 1, part A

variable name: CMONHERE

(CIVILIAN PROVIDER)

7. How long have you worked here at [PRIMUS] [Winn] [Tuttle]?

code number of months

card: 1
column(s): 22
question: 2, part A

variable name: CWASAD

(CIVILIAN PROVIDER)

8. Have you served on active duty as a health care provider?

1 = YES

2 = NO

card: 1
column(s): 23 - 25
question: 2, part A

variable name: CMONAD

(CIVILIAN PROVIDER)

9. IF YES:

code number of months as an active duty provider

card: 1
column(s): 26 - 28
question: 2, part A

variable name: CMONOUT

(CIVILIAN PROVIDER)

10. How long has it been since you left? _____

code number of months

card: 1
column(s): 29
question: 3, part A

variable name: CTRAIN

11. Did your professional health care training take place in a
military facility, a civilian facility, or some of both?

1 = military facility
2 = civilian facility
3 = both

card: 1
column(s): 30 - 32
question: 3, part A

variable name: CCTRAIN

(CIVILIAN PROVIDER)

12. If "some of both": How many years of training in a
civilian setting?

code number of months

card: 1
column(s): 33 - 35
question: 3, part A

variable name: CMTRAIN

(CIVILIAN PROVIDER)

13. If "some of both" how many years training in a military
setting?

code number of months

card: 1
column(s): 36
question 3, part A

variable name: CANYPAY

(CIVILIAN PROVIDER)

14. If all civilian:

Was any portion of the civilian training paid for by the
army?

1=yes 2=no

card: 1
column(s): 37 - 39
question: 3, part A

variable name: CMILPAY

(CIVILIAN PROVIDER)

15. If all civilian:

What portion of the civilian training was paid for by
the army?

code number of months

card: 1
column(s): 40 - 42
question: 4, part A

variable name: CWORKMIL

(CIVILIAN PROVIDER)

16. Of your years working as a health care professional,
how many have been in a military setting?

code number of months (code 0 for none)

card: 1
column(s): 43 - 45
question: 4, part A

variable name: CWORKCIV

(CIVILIAN PROVIDER)

17. Of your years working as a health care professional, how
many have been in civilian settings?

code number of months (code 0 for none)

Part AA

FOR (ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

card: 1 variable name: MYRENT
column(s): 46 - 47
question: 3, part AA

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

18. When did you first enter the Army?

code last two digits of year

card: 1 variable name: MNOBREAK
column(s): 48
question: 2, part AA

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

19. Has your service been continuous since _____ (year
first entered)?

1 = yes

2 = no

card: 1 variable name: MMONOUT
column(s): 49 - 51
question: 2, part AA

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

20. Number of years interrupted

code number of months

card: 1 variable name: DATPOST
column(s): 52 - 55
question: 3, part AA

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

21. When did you come to Ft. Stewart for this tour of duty?

52 - 53 month = 1 - 12, right justified (MPOST)

54 - 55 last two digits of year (YRPOST)

card: 1
column(s): 56
question: 4, part AA

variable name: MTRAIN

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

22. Did your professional health care training take place in a military facility, a civilian facility, or some of both?

1 = military facility
2 = civilian facility
3 = both

card: 1
column(s): 57 - 59
question: 4, part AA

variable name: MCTRAIN

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

23. If "some of both": How many years in a civilian setting,

code number of months

card: 1
column(s): 60 - 62
question: 4, part AA

variable name: MMTRAIN

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

24. If "some of both": How many years in a military setting?

code number of months

card: 1
column(s): 63
question: 4, part AA

variable name: MANYPAY

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

25. If all civilian:

Was any portion of the civilian training paid for by the army?

1=yes

2=no

card: 1
column(s): 64 - 66
question: 4, part AA

variable name: MMILPAY

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

26. If all civilian:

What portion of the civilian training was paid for by
the army?

code number of months

card: 1
column(s): 67
question: 5 part AA

variable name: MPAYBACK

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

27. Are you currently serving a pay-back period?

1 = Yes

2 = No

card: 1
column(s): 68 - 70
question: 6, part AA

variable name: MWORKMIL

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

28. Of your years working as a health care professional,
how many have been in military settings?

code number of months

0 = none

card: 1
column(s): 71 - 73
question: 6, part AA

variable name: MWORKCIV

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

29. Of your years working as a health care professional,
how many years have been in civilian settings?

code number of months

0 = none

card: 1
column(s): 74
question: 8, part AA

variable name: MSTAYMIL

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

30. What are your career plans-- will you stay in the military until you retire, leave after a pay-back period, or what?

- 1 = stay in until retire
- 2 = leave after pay-back
- 3 = leave (other reasons)
- 4 = other

card: 1
column(s): 75
question: 9, part AA

variable name: MJOBFAM

(ACTIVE DUTY PRIMARY HEALTH CARE PROVIDERS)

31. From your experience, would you say that job or family factors are most important in decision to stay in or leave the Army?

- 1 = job factors
- 2 = family factors
- 3 = both

card: 2
column(s): 1

32. card #2

card: 2
column(s): 2 - 4

variable name: IDNUM

33. Three digit interview identification number

e.g.: 1,.....50,.....100....759

Part AAA

(FOR ALL CLINIC SUPPORT SERVICE STAFF)

card: 2 variable name: SYRCOME
column(s): 5 - 6
question: 1, part AAA

(FOR ALL CLINIC SUPPORT SERVICE STAFF)

34. When did you first start working at an Army installation?
code last two digits of Year

card: 2 variable name: SMONHERE
column(s): 7 - 9
question: 2, part AAA

(FOR ALL CLINIC SUPPORT SERVICE STAFF)

35. For how long have you worked here [PRIMUS] [WINN-
MEDDAC] [WINN-DENTAC] [TUTTLE]?
code number of months

card: 2 variable name: SMOJOUT
column(s): 10 - 12
question: 3, part AAA

(FOR ALL CLINIC SUPPORT SERVICE STAFF)

36. If respondents has not worked continuously for the
Army, how many years interrupted service?
code number of months

card: 2 variable name: SJOBCHG
column(s): 13 - 14
question: 4, part AAA

(FOR ALL CLINIC SUPPORT SERVICE STAFF)

37. How many job changes have you had since you began
working at [FT. STEWART] [TUTTLE] [PRIMUS]?
code number of job changes, right justified

Part B

(FOR ALL RESPONDENTS)

card: 2
column(s): 15
question: 1 part B

variable name: OFFDIFF

(FOR ALL RESPONDENTS)

38. Do you think officers and their families are treated differently from enlisted personnel and their families when they come for health care?

- 1 = yes
- 2 = no
- 3 = don't know/NA

card: 2
column(s): 16
question: 2, part B

variable name: FDEPDIF

(FOR ALL RESPONDENTS)

39. In matters of health care, do you think female dependents are treated differently from active duty women?

- 1 = yes
- 2 = no
- 3 = don't know/NA

card: 2
column(s): 17
question: 3, part B

variable name: ADDIF

(FOR ALL RESPONDENTS)

40. Do you feel that AD members receive the same quality of health care as dependents?

- 1 = yes
- 2 = no
- 3 = don't know/NA

card: 2
column(s): 18
question: 4, part B

variable name: RETDIF

(FOR ALL RESPONDENTS)

41. Do you think the health care received by retirees is different from that received by dependents of active duty soldiers?

1 = yes
2 = no
3 = don't know/NA

card: 2
column(s): 19
question: 5, part B

variable name: DEPVCIIV

(FOR ALL RESPONDENTS)

42. Would you say the health care dependents receive in the Army is better, worse or about the same as what they would receive if they were civilians?

1 = Better
2 = Worse
3 = Same

card: 2
column(s): 20
question: 7, part B

variable name: BOTHR

(FOR ALL PRIMARY HEALTH CARE PROVIDERS)

43. Speaking from recent experience in this clinic, which one has the greatest impact on patient satisfaction?

1 = (a) difficulty in obtaining an appointment;
2 = (b) experiencing a long wait;
3 = (c) getting a rushed examination;
4 = (d) receiving an inadequate explanation;
5 = (e) seeing someone different on every visit;
6 = (f) lack of esprit de corps in the clinic.

card: 2
column(s): 21
question: 7, part B

variable name: NOBOTH

(FOR ALL PRIMARY HEALTH CARE PROVIDERS)

44. Which one has the least impact on patient satisfaction?

- 1 = (a) difficulty in obtaining an appointment
- 2 = (b) experiencing a long wait
- 3 = (c) getting a rushed examination
- 4 = (d) receiving an inadequate explanation
- 5 = (e) seeing someone different on every visit
- 6 = (f) lack of esprit de corps in the clinic

card: 2
column(s): 22
question: 8, part B

variable name: UBOTH

(FOR ALL PRIMARY HEALTH CARE PROVIDERS)

45. Considering your own recent work in this clinic, which one has the greatest effect on your work?

- 1 = (a) difficulty in obtaining an appointment
- 2 = (b) experiencing a long wait
- 3 = (c) getting a rushed examination
- 4 = (d) receiving an inadequate explanation
- 5 = (e) seeing someone different on every visit
- 6 = (f) lack of esprit de corps in the clinic

card: 2
column(s): 23
question: 9, part B

variable name: UNOBOTH

(Missing for Version 2)

(FOR ALL PRIMARY HEALTH CARE PROVIDERS)

46. Which one affects you the least.

- 1 = (a) difficulty in obtaining an appointment
- 2 = (b) experiencing a long wait
- 3 = (c) getting a rushed examination
- 4 = (d) receiving an inadequate explanation
- 5 = (e) seeing someone different on every visit
- 6 = (f) lack of esprit de corps in the clinic

Part C

card: 2
column(s): 24
question: 1, part C

variable name: FAMPRAC

(FOR ALL PRIMARY HEALTH CARE PROVIDERS)

(FOR RESPONDENTS OTHER THAN PRIMARY HEALTHCARE PROVIDERS)

47. A serious problem with military health care is that health care for the whole family in a family practice style clinic is less available than is expected.

1 = not serious
2 = somewhat serious
3 = very serious
4 = don't know/NA

Card: 2
Column(s): 25
question: 2a, part C

variable name: MOTHER

(FOR ALL PRIMARY HEALTH CARE PROVIDERS)

(FOR RESPONDENTS OTHER THAN PRIMARY HEALTHCARE PROVIDERS)

48. A serious problem with military health care is that too many patients expect "Mother Army" will take care of them, so they don't have to think and care for themselves.

1 = not serious
2 = somewhat serious
3 = very serious
4 = don't know/NA

card: 2 variable name: FINDCARE
column(s): 26
question: 2b, part C (Missing on Version 2)

(FOR ALL PRIMARY HEALTH CARE PROVIDERS)

(FOR RESPONDENTS OTHER THAN PRIMARY HEALTHCARE)

49. A serious problem with military health care is that the patient is expected to find the right place to get care.

- 1 = not serious
- 2 = somewhat serious
- 3 = very serious
- 4 = don't know/NA

card: 2 variable name: ALLFREE
column(s): 27
question: 3, part C

(FOR ALL PRIMARY HEALTH CARE PROVIDERS)

(FOR RESPONDENTS OTHER THAN HEALTHCARE PROVIDERS)

50. A serious problem with military health care is the patient attitude of "It's all free. Do something for me".

- 1 = not serious
- 2 = somewhat serious
- 3 = very serious
- 4 = don't know/NA

card: 2 variable name: PROMISE
column(s): 28
question: 4, part C

(FOR ALL PRIMARY HEALTH CARE PROVIDERS)

(FOR RESPONDENTS OTHER THAN PRIMARY HEALTHCARE PROVIDERS)

51. A serious problem with military health care is that it promises more than it can deliver.

- 1 = no serious
 - 2 = somewhat serious
 - 3 = very serious
 - 4 = don't know/NA
-

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

card: 2
column(s): 29
question: 5, part C

variable name: EXPECT

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

52. A serious problem with Army medical practice is that patients expect less of military health professionals than of civilian health professionals.

- 1 = not serious
- 2 = somewhat serious
- 3 = very serious
- 4 = don't know/NA

card: 2
column(s): 30
question: 6, part C

variable name: ROSYVIEW

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

53. A serious problem in military medicine is that most of its health professionals have rosy views of what is normal health care in the outside world.

- 1 = not serious
- 2 = somewhat serious
- 3 = very serious
- 4 = don't know/NA

card: 2
column(s): 31
question: 7, part C

variable name: WARTIME

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

54. A serious problem with the practice of military health care is harmonizing our peace-time servicing of civilian dependents with our war-time mission to casualties.

- 1 = not serious
 - 2 = somewhat serious
 - 3 = very serious
 - 4 = don't know/NA
-

card: 2
column(s): 32
question: 8, part C

variable name: QUALITY

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

55. A serious problem with military medicine is the conflict between giving the highest quality of care and meeting "provider productivity" quotas.

1 = not serious
2 = somewhat serious
3 = very serious
4 = don't know/NA

card: 2
column(s): 33
question: 9, part C

variable name: BADJOB

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

56. A serious problem with the military health care system is that there are not enough penalties for doing a bad job.

1 = not serious
2 = somewhat serious
3 = very serious
4 = don't know/NA

card: 2
column(s): 34
question: 10, part C

variable name: MINORILL

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

57. A serious problem in the practice of military medicine is dealing with patients who seek care for minor ailments for which in the civilian world they would go to the drugstore.

1 = not serious
2 = somewhat serious
3 = very serious
4 = don't know/ NA

card: 2
column(s): 35
question: 11, part C

variable name: PSYCHO

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

58. A serious problem with military medicine is that despite the known overlap between psychiatric and physical morbidity, this co-morbidity factor is glossed over in clinic practice.

1 = not serious
2 = somewhat serious
3 = very serious
4 = don't know/NA

card: 2
column(s): 36
question: 12a, part C

variable name: COMSKILL

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

59. A serious problem with military healthcare is that physicians and other professionals are not adequately trained in effective personal communication skills.

1 = not serious
2 = somewhat serious
3 = very serious
4 = don't know/NA

card: 2
column(s): 37
question: 12b, part C

variable name: USESKILL

[FOR ALL PRIMARY HEALTH CARE PROVIDERS ONLY]

60. A serious problem is not so much the lack of health professional training in communication skills, but that they don't take the time to utilize the skills they do possess.

1 = not serious
2 = somewhat serious
3 = very serious
4 = don't know/NA

PART D

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

card: 2 variable name: REASSURE
column(s): 38
question: 1, part D

61. In general, it is more practical to reassure patients than to inform them about their condition.

1 = Generally true
2 = Generally not true
3 = don't know/NA

card: 2 variable name: PICTURE
column(s): 39
question: 2, part D

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

62. In general, is it best to draw pictures or show models to explain the CAUSES of a patient's condition, instead of just giving a verbal explanation?

1 = Generally true
2 = Generally not true
3 = don't know/NA

card: 2 variable name: HOPE
column(s): 40
question: 3, part D

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

63. In general, it is best that your explanation of the RESULTS obtainable from treatment awakens HOPE in a patient.

1 = Generally true
2 = Generally not true
3 = don't know/NA

card: 2 variable name: FEAR
column(s): 41
question: 4, part D

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

64. In general, it is best to instill a bit of FEAR in a patient about the consequences of not following orders.

1 = Generally true

2 = Generally not true
3 = don't know/NA

card: 2
column(s): 42
question: 5, part D

variable name: EXPLAIN

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

65. In general, in clinical practice, it is better to instruct and explain in detail why a procedure or regimen has to be done.

1 = Generally true
2 = Generally not true
3 = don't know/NA

card: 2
column(s): 43
question: 6, part D

variable name: REASONS

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

66. In general, it is better to spend less TIME with the patient discussing the cause of his condition, and more TIME discussing the reasons for his treatment.

1 = Generally true
2 = Generally not true
3 = don't know/NA

card: 2
column(s): 44
question: 7, part D

variable name: UNCERTAN

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

67. In general, when talking with the patient, it is best to avoid discussing anything that suggests UNCERTAINTY.

1 = Generally true
2 = Generally not true
3 = don't know/NA

card: 2
column(s): 45
question: 8, part D

variable name: WORRY

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

68. In general, it is best to encourage the patient to learn about his condition, even if it causes him some WORRY.

1 = Generally true

2 = Generally not true
3 = don't know/NA

card: 2
column(s): 46
question: 9, part D

variable name: BODY

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

69. In general, during a clinic visit, what a patient is told about his HEALTH STATUS and body functioning is at least as important as the treatment he receives for his condition.

1 = Generally true
2 = Generally not true
3 = don't know/NA

card: 2
column(s): 47
question: 10, part D

variable name: BIOPSYCH

[FOR ALL PRIMARY HEALTH CARE PROVIDERS EXCEPT PHARMACISTS]

70. In general, forcing a distinction between biological and psychological influences on unexplained symptoms is both necessary and productive in clinic practice.

1 = Generally true
2 = Generally not true
3 = don't know/NA

Part E

(FOR PRIMARY HEALTH CARE PROVIDERS, FOR CLINIC STAFF, AND PHARMACISTS)

card: 2
column(s): 48
question: 1, part E

variable name: RAPPORT

(FOR PRIMARY HEALTH CARE PROVIDERS, FOR CLINIC STAFF, AND PHARMACISTS)

71. So many of our clinic patients are convinced they need more rapport and attention than we have time to give.

1 = agree 2 = disagree 3 = DK/NA

card: 2
column(s): 49
question: 2, part E

variable name: LOOKAFTR

(FOR PRIMARY HEALTH CARE PROVIDERS, FOR CLINIC STAFF, AND PHARMACISTS)

72. So many military dependents want more attention from us because they don't feel looked after enough in their daily lives.

1 = Agree

2 = Disagree

3 = DK/NA

card: 2
column(s): 50
question: 3, part E

variable name: CONGRESS

(FOR PRIMARY HEALTH CARE PROVIDERS, FOR CLINIC STAFF, AND PHARMACISTS)

73. If you wish to change the military medical care system, it is more important to reach one legislator than five administrators or ten doctors.

1 = Agree

2 = Disagree

3 = DK/NA

card: 2
Column(s): 51
question: 4, part E

variable name: GIVEINFO

[FOR ALL PRIMARY HEALTH CARE PROVIDERS]

74. Spending time giving out health care information cuts down the daily productivity count of the clinic (MCCU's) and diminishes the quality of patient care evenmore.

1 = Agree

2 = Disagree

3 = DK/NA

card: 2
Column(s): 52
question: 5, part E

variable name: CHAIN

[FOR ALL PRIMARY HEALTH CARE PROVIDERS]

75. The QA system now in use at Army hospitals and clinics merely makes everyone move reports up the chain of command.

1 = Agree

2 = Disagree

3 = DK/NA

card: 2
Column(s): 53
question: 6, part E

variable name: WORKLOAD

[FOR ALL PRIMARY HEALTH CARE PROVIDERS]

76. When you work in an Army clinic, you don't have the control over your 'work load' that you do in private practice.

1 = Agree

2 = Disagree

3 = DK/NA

card: 2
column(s): 54
question: 7, part E

variable name: SELFCARE

[FOR ALL PRIMARY HEALTH CARE PROVIDERS]

77. Please consider this statement: "In recent years, too much has been written about the therapeutic virtues of health self-care, while too little has been said about its limits and risks for everyone concerned."

1 = Agree

2 = Disagree

3 = DK/NA

Part F (This section missing on version 2, skip to col. 59 on v.2)

card: 2
column(s): 55
question: 1a, part F

variable name: PRIORITY

[FOR ALL PRIMARY HEALTH CARE PROVIDERS]

78. In light of your experience, which of these four activities has priority over all others?

1 = patient evaluation

2 = handling

3 = treatment

4 = caregiving

5 = all are equal

card: 2
Column(s): 56
question: 1b, part F

variable name: DOWO

[FOR ALL PRIMARY HEALTH CARE PROVIDERS]

79. In your view, which one of the above can you not do without?

- 1 = patient evaluation
 - 2 = handling
 - 3 = treatment
 - 4 = caregiving
 - 5 = none, all equally needed
-

card: 2
column(s): 57
question: 1c, part F

variable name: ELIMIN

[FOR ALL PRIMARY HEALTH CARE PROVIDERS]

80. In your view, which one of the above could you eliminate without repercussions?

- 1 = patient evaluation
 - 2 = handling
 - 3 = treatment
 - 4 = caregiving
 - 5 = none
-

card: 2
column(s): 58
question: 2, part F

variable name: TOE

81. In your opinion, how different is TOE* field or MASH unit work from your clinic work here?

- 1 = Very much
 - 2 = Little
 - 3 = Same
 - 4 = DK/NA
-

Part G

[FOR ACTIVE DUTY PERSONNEL, INCLUDING TENANT UNITS]

card: 2 variable name: PRIMUS
columns(s): 59
question: 1, part G

82. During the past year, (If less, add: since you have been at Ft. Stewart) have you, your spouse or your children had occasion to receive medical care?

Primus

1 = respondent 2 = spouse 3 = children
4 = respondent & spouse 5 = respondent & children
6 = spouse & children 7 = respondent, spouse & children
0 = not used

card: 2 variable name: WINNER
column(s): 60
question: 1, part G

83. WINN Emergency Clinic

1 = respondent 2 = spouse 3 = children
4 = respondent & spouse 5 = respondent & children
6 = spouse & children 7 = respondent, spouse & children
0 = not used

card: 2 variable name: WINNCLIN
column(s): 61
question: 1, part G.

84. WINN Specialty Clinic

1 = respondent 2 = spouse 3 = children
4 = respondent & spouse 5 = respondent & children
6 = spouse & children 7 = respondent, spouse & children
0 = not used

card: 2 variable name: DENTAL
column(s): 62
question: 1, part G

85. DENTAL Clinic

1 = respondent 2 = spouse 3 = children
4 = respondent & spouse 5 = respondent & children
6 = spouse & children 7 = respondent, spouse & children
0 = not used

card: 2
column(s): 63
question: 1, part G

variable name: TUTTLE

86. TUTTLE Clinic

1 = respondent	2 = spouse	3 = children
4 = respondent & spouse	5 = respondent & children	
6 = spouse & children	7 = respondent, spouse & children	
0 = not used		

card: 2
column(s): 64
question: 1, part G

variable name: GORDON

87. Ft. Gordon Medical Center

1 = respondent	2 = spouse	3 = children
4 = respondent & spouse	5 = respondent & children	
6 = spouse & children	7 = respondent, spouse & children	
0 = not used		

card: 2
column(s): 65
question: 1, part G

variable name: CIVDOC

88. Civilian hospital or physician

1 = respondent	2 = spouse	3 = children
4 = respondent & spouse	5 = respondent & children	
6 = spouse & children	7 = respondent, spouse & children	
0 = not used		

card: 2
column(s): 66
question: 2, part G

variable name: NOTTELL

[FOR ACTIVE DUTY]

89. Since you have been with the Army, have you ever thought a physician treating you failed to tell you something you needed to know?

1 = Yes	2 = No
---------	--------

card : 2
column(s): 67
question: 3, part G

variable name: CIVCARE

[FOR ACTIVE DUTY]

90. If you were to leave the Army today, do you think the medical care you would receive in the civilian world would be (a) better, (b) the same or (c) worse than you can get in the Army?

1 = Better

2 = Worse

3 = Same

Card: 2
column(s): 68
question: 5, part G

variable name: CHIRO

91. Has there been an occasion when you had the need to obtain treatment or advice from someone other than "mainstream" medical care provider (someone like a chiropractor, or some form of "alternative care" for instance)?

1 = Yes

2 = No

card: 2
column(s): 69
question: 7, part G

variable name: GROWUP

[FOR ACTIVE DUTY]

92. Would you say the health care you received while you were growing up was better, worse or about the same as the health care you now receive in the Army?

1 = Better

2 = Worse

3 = Same

card: 2
column(s): 70
question: 8, part G

variable name: UNHAPPY

93. If you were under the care of an Army physician, and were unhappy about the care you were getting, what would you do about it?

Has that happened to you?

1 = YES

2 = NO

card: 3
column(s): 1

94. Card #3

card: 3
column(s): 2-4

variable name:

95. three-digit interview identification number, right justified

e.g.: 1,...50...100,...750

Part H

[FOR ALL RESPONDENTS]

card: 3
column(s): 5
question: 1, part H

variable name: CLIMATE

96. How would you rate the "human climate" here, I mean the atmosphere in the workplace. Would you say it is pleasant, unpleasant, or somewhere in-between?

1 = Pleasant 2 = Unpleasant
3 = Somewhere in-between

card: 3
column(s): 6
question: 1, part H

variable name: HOSTILE

97. If unpleasant or in-between: Would you say any of the following words describes the atmosphere:

a. too hostile

1 = Yes 2 = No

card: 3
column(s): 7
question: 1, part H

variable name: ALOOF

98. b. too aloof

1 = Yes 2 = No

Card: 3
column(s): 8
question: 1, part H

variable name: COMPETE

99. c. too competitive

1 = Yes 2 = No

card: 3
column(s): 9
question: 1, part H

variable name: EASYGO

100. d. too easy-going

1 = Yes 2 = No

card: 3
column(s): 10
question: 1, part 4

variable name: HIGHPRES

101. e. too high-pressure

1 = Yes 2 = No

card: 3
column(s): 11
question: 2, part H

variable name: GRATIFY

[FOR AD HEALTH CARE PROVIDERS]

102. Does the work you do as an Army health provider gratify you more, less, or about the same as when you first began working for the Army?

1 = More 2 = Less 3 = Same

card: 3
column(s): 12
question: 3, part H

variable name: SUEDOC

[FOR AD HEALTH CARE PROVIDERS]

103. Since more and more of today's patients feel, or rather are free to sue doctors and hospitals for malpractice, how much does this seem to affect your work at this clinic?

1 = A lot 2 = A little 3 = Not at all

card: 3
column(s): 13 - 16
face sheet

variable name: HREND

104. Interview End Time:

Military Time 60 - 61 = Hours (01 - 24) HOUREND
62 - 63 = Minutes (01 - 59) MINEND

card: 3
column(s): 17
back sheet

variable name: COMFORT

105. Was Respondent comfortable:

1 = Yes 2 = No

card: 3
column(s): 18
back sheet

variable name: INTEREST

106. Was Respondent interested:

1 = YES 2 = NO

card: 3
column(s): 19
back sheet

variable name: SEX

107. Respondent's Sex

1 = Male 2 = Female

card: 3
columns: 20 - 21
back sheet

variable name: RANK

108. AD ONLY: Respondent's Rank:

1 = E1	7 = E7	13 = W4	19 = 06 Col.
2 = E2 priv.	8 = E8	14 = 01 2nd Lt.	20 = 07 BrigGen.
3 = E3 PFC	9 = E9	15 = 02 1st Lt.	21 = 08 MajGen.
4 = E4 CPL	10 = W1	16 = 03 Capt.	22 = 09 LtGen.
5 = E5 SGT	11 = W2	17 = 04 Major	23 = 00 Gen.
6 = E6 1st SGT	12 = W3	18 = 05 LTC	24 = not in Army

card: 3
column(s): 22
back sheet

variable name: STATUS

109. Respondent's Status

- 1 = Active Duty
- 2 = Reserve
- 3 = Other

card: 3
column(s): 23 - 24
back sheet

variable name: AGE

110. Respondent's Age

In years

card: 3
column(s): 25
back sheet

variable name: RACE

111. Respondent's Race
- 1 = White
 - 2 = Black
 - 3 = Hispanic
 - 4 = American Native
 - 5 = Other

card: 3
column(s): 26
front and/or back sheet

112. Interviewer's Name

- 1 = Bonnie Coats
- 2 = Barbara Hendry
- 3 = John Henretta
- 4 = Joan McTigue
- 5 = Darrel Miller
- 6 = Susannah Neal
- 7 = Otto Von Mering

M E M O R A N D U M

TO: Walter Reed Research Staff

DATE: July 6, 1989

RE: Schedule for Coding the Provider Interviews

Thursday, July 6:	Lois and Barbara	1:00-3:00
Friday, July 7:	Barbara and Susannah	2:30-4:30
Monday, July 10:	Barbara and Lois	1:00-3:00
Tuesday, July 11:	Barbara and Susannah	3:00-5:00
Wed, July 12:	Barbara and Lois	1:00-3:00
Monday, July 17:	Brandon and Lois	1:00-3:30
Tuesday, July 18:	Barbara and Susannah	3:00-5:00
Wed, July 19:	Lois and Brandon	1:00-3:30

cc: OVM
BH
LR
SN
BW

Provisional thematic analysis of fieldnotes from provider interview phase identified the following themes as of 8/5/89:

- I. Provider Perceptions of Problem Areas in Military Health Care:
 - A. Overuse of facilities by patients
 - B. Overuse of Emergency Room as outpatient clinic
 - C. Conflict between meeting productivity quotas and providing quality care.
 - D. Need to revamp the appointment system
 - E. Preferential care given to higher ranking officers and families.
 - F. Army promises more in the way of health care than it can actually deliver, so patients have high expectations
- II. Provider Satisfaction with work themes:
 - A. Satisfaction levels vary between clinics
 - B. Satisfaction level related to providers' perceptions of patients
 - C. Areas of dissatisfaction affecting decision to go to civilian practice:
 - 1. salary inequities between military and civilian
 - 2. less opportunity to provide continuity of care and to get to know patients in military.
 - D. Areas of satisfaction affecting decision to stay in military medicine:
 - 1. able to provide needed tests and procedures in military without worrying whether the patient can pay for it.
 - 2. very expensive to set up a private practice

March 22, 1989-DENTAC (Provider Interview)

Interviewed a dental assistant at Dentac this morning. One of the most interesting things she suggested is that military health care employees can "get away with more" than civilian health care employees here in Dentac (civilian employees are reprimanded more severely in the army than military). For example, she said that here in Dentac there is a military dent. asst. who is not a good worker (no drs. want to work with him) but he has never been counseled or "dealt with" in any way. She feels that if he were a civilian employee that action would be taken to either counsel or fire him.

April 21, 1989- Blood Bank/Lab WINN.

First interview was particularly interesting because R is an AD chemistry supervisor at the WINN lab and also works at Liberty Hospital in the evenings. According to him, many of the health care employees at Liberty also work at WINN either as civilian or active duty. R pointed out that this is very interesting when considering that many army clients CHAMPUS out and go to Liberty because they think they are getting better care. However, according to R, in actuality the facilities at Liberty are not as good as those at WINN and the staff at Liberty is the same or perhaps less than at WINN.

Noticed that the viewpoints of lab workers are different from other types of providers and clients. For one, many lab workers said they think Army health care is more thorough than civilian because in the army the doctor can do more tests without worrying about the cost. Some also have a unique view of what patient evaluation, treatment, handling, and caregiving are. Some respondents said that the treatment is the drawing of the blood while others maintained a broader perspective and say lab work is part of the diagnostic procedure and not involved in treatment at all.

June 8, 1989

Interesting to note the correlation between patient dissatisfaction over not seeing same dr. and poor continuity of care with the provider attitude that "we don't like to see the same patients again and again." This is what a doctor in the Medical Clinic told me. He also said specifically that he particularly dislikes treating retirees with chronic problems. His preferred type of patient is one which he can treat quickly and never have to see again for the same problem.

More generally, I feel that many of the providers whom I have interviewed are of the opinion that one of the biggest problems (if not the biggest) with army medicine is over-use of the system. Some providers felt that the over-use of the system is directly related to the fact that care is free. In fact several physicians suggested that even a minimal charge of \$1 per visit would make the patient think more carefully before going to the clinic and perhaps utilize more self care.

Nonetheless, whatever the cause or more probably multiple causes of over-use are, the consequence is clearly dissatisfaction for both client and provider. Perhaps the most common complaint of the providers I have talked to is the "productivity quota" which many of them are required to meet. Doctors complain about the lower quality of care and minimal amount of time that they have with their patients. It seems that they are just as frustrated and dissatisfied with the system as the patients are.

The exceptions to this seemingly widespread dissatisfaction, however, do exist in the smaller specialized clinics. From my experience, it is clear that the providers in physical therapy, and occupational therapy are actually quite pleased with their situation. In their case they actually have more responsibility and freedom to practice their form of health care than they would in the civilian sector. Also, because patients must be referred to the clinic or be suffering from a special type of problem, these clinics do not experience the over-use that other walk-in clinics do. These two therapy clinics seemed to me to be very efficient and autonomous units which only tangentially experience the problems and concerns of the other WINN clinics.

Some brief impressions of the clinics:

ER; I only interviewed one nurse there. It is definitely understaffed and there is the sense of chaos there. Not necessarily in terms of disorganization, but of there being a lot going on and a lot of people running around. Of all the times that I have been in ER for either client or provider interviews I have seen very few patients in the waiting or treatment areas with an emergency.

FP: Both of the doctors that I interviewed at FP were just out of medical school. Both of them seemed to be fairly conservative men who did not strike me as very compassionate people. One definitely left me with the impression that he is more concerned about his career than with patients. Also neither of these doctors gave me the impression that they had any experience with medicine or health outside of their medical school training. To me their views seemed to be very narrow. They had no ideas about self-care, promotion, client-provider rapport, alternative health care, or any of the important economic and social issues which are related to health among army soldiers.

PEDS: I had two very different interviews with the doctors in Peds. One was with a young female doctor who had strong opinions about the army and the army health care system. She seemed to be very involved with her patients and very concerned about the welfare of her patients. She talked at length about the fact that young army families do not receive the economic or social support that they need. She pointed to child and spouse abuse as one of the worst consequences of this situation. However, while she seemed to be very aware and generally concerned about her patients situation and health status, she also was very resentful about the way that she was treated by her own patients as well as by the "system". For example, she said that patients are very

demanding and rude and do not treat her with any respect. Moreover, she said that because of provider productivity quotas and the shortage of support staff she has no time to spend with patients, has too many patients to see, and is also expected to keep up with paper work. I really felt sorry for this woman. She definitely was upset about her situation and looking forward to getting out.

On the other hand, I also interviewed a female physician in PEDS who had a very different attitude. This doctor was extraordinarily relaxed. Her attitude was very accepting of her situation and though she recognizes the biggest problem of army medicine is too many patient and too few doctors--this does not seem to affect her attitude towards her work.

Fieldnotes - 1989 - B. Hendry

March 22 - dentist -

Offered criticism of the questionnaire - he said it focused on the negative and that he was left afterwards feeling he'd only gotten to voice negative opinions, views, when, in reality, he has a lot of positive feelings and views about being an Army dentist.

He came from an Army background - his father was in the Army. When he first started working in the Army, he thought he would make a career of it. He was obligated to stay in for four years to pay back the ROTC support he got for his undergraduate education. He completed those four years and stayed in two more but is now getting out because of the following factors:

1. money - he gets only half of what he could earn on the outside.

2. he would like to do different kind of work insofar as establishing a practice in one area where he would see the same people over time and be able to establish continuity of care with them.

He made the point that yes, people are led to expect more than they can actually get in Army medical care and he feels it is unfair that he is the one who has to end up telling them, when he has nothing to do with the decision-making -- He feels this information should be disseminated from higher levels and people should be told honestly what they will get before they reach his level.

3/22 - Dentac IV - receptionist:

She said that dependent patients seem to like the new appointment system better. They come in and get evaluated for what they need, then get on a list for that thing, to be called when there's open appointments for that particular procedure -- usually takes 3-4 weeks for them to get called, but eliminates them having to call and get frustrated by b. signals, calling on the wrong day, or the schedule being full and them having to recall.

Also, regarding retirees, she said she's seen them sometimes wait all day for a cancellation and not even get seen. She thinks this is unfair after they've put twenty years in -- thinks there should be 1-2 days a month set aside for them to be able to make appointments.

3/22 - dental assistant:

I don't think this respondent understood a number of the questions, but rather, just answered them quickly to get through. I wonder how appropriate some of the more medical questions are for lower ranking health care providers who just do basic technical tasks.

3/22 - dentist

This dentist noted a big difference between Dental clinic #4 and #1 as she had worked in both. She suggested we would get

very varying results if we did interviews in #1 - that, because of the way the clinics are run, dissatisfaction levels would be much higher among both staff and patients at #1. She was concerned that our survey would be biased by only interviewing in #4.

Also, she had a lot to say about people coming in for minor things at emergency sick call and that this was not all their fault but due to the nature of the system: e.g. - the system promises more than it can deliver -- people can't get it for regular appointments for routine care so they come to e.r. sick call -- also, she said this is not discouraged by the administrators as they want to maintain the illusion of being able to adequately care for everyone.

She also emphasized that preferential care is given to high ranking officers and their dependents, because of the heads of the clinics not wanting to rock the boat. She gave a specific example of being asked to be especially nice to a colonel's wife and child. She said the staff wants to give equitable care, but that supervisors often tell them to give preferential treatment.

She is getting out of Army when her four year payback is up for several reasons -- one main one being that she wants to specialize in children's' dentistry and there's not really the option to do that in the Army.

Another dentist also mentioned the variation between the different dental clinics as far as the scope of procedures a new, incoming dentist could do. Since there are specialist dentists in the clinics, new younger dentists often get to do only basic, routine care. He said he likes clinic 4 because he is given more freedom to do a variety of procedures and the sr. staff are willing to help him -- this adds to job interest and satisfaction.

3/23 - Family Practice clinic

Some general impressions: I interviewed six medical specialists at this clinic. Their interest in the questionnaire and ability to understand and answer the questions varied quite a bit. Unlike E4's interviewed in the general patient population phase, most of these E4's were in the Army with the specific plan to get the GI bill to go to college, usually in a medical related area, and were not planning on Army careers. As one young man told me, he fell through all the cracks for getting financial aid to go to college -- his parents made just over the limit for him to qualify for low interest loans, his grades were not quite high enough or his athletic talents outstanding enough to get an academic or athletic scholarship, so, he thought he would get college benefits by going into the Army.

Another interesting area that all the specs. commented a lot on was the difference in the kind of work they do in the field as compared to in the hospital. In the field, they get to do a lot more variety of medical procedures (e.g. giving IV's, doing stitches), but they also have to do a lot of non-medical hard and dirty maintenance work keeping up the equipment, etc. Some said

they spent a majority of time doing this kind of work and not much doing the medical.

4/21 - Dental Clinic I.

Interviewed a civilian dental assistant married to an active duty soldier. They've been in the Army 18 years, so she was very familiar with, and knowledgeable of, military medicine. She worked at an Army hospital in Germany as a central appointments clerk. She said she never liked to tell people what her job was because everyone hated the appointment system so much, she didn't like to admit she was associated with it. She sees this as a problem throughout the Army health care system and the one which poses the biggest hassle for patients -- it is so difficult for them to just get through to make an appointment.

WINN Committee Notes On File

Health Promotion Committee Meetings

Seventeen Committee Notes from June 1987 to June 1989.

Health Advisory Committee

Twenty-four Committee Notes from June 1987 to June 1989.

Health Care Consumers Committee

Sixteen Committee Notes from June 1987 to May 1989.

Market/Strategy and Planning Committee

Twenty-six Committee Notes from June 1987 to June 1989.

Analysis of the Ft. Stewart In-House Survey on Staff Perception and Satisfaction

A. General Issues:

Civilian media reports of Army medicine have been extremely negative since 1982. The focus has been on inadequately trained medical personnel and some medical incidents with adverse outcomes. These occurrences have been used as examples of the incompetence of the Army medical staff. Factors perceived as not directly associated with the quality of health care such as long waits, misplaced medical records, rude personnel, and deteriorating physical plants with inadequate parking facilities have also created the perception that health care providers "don't care" about soldiers and their families. Congress has focused on these reports questioning the quality of Army medicine. To counteract this negative perception of Army health care the AMEDD marketing strategy suggests that "it is vital that we communicate with candor" both the weaknesses as well as the strengths in the Army health care delivery system. If there are problems, they must be addressed.

B. The Ft. Stewart Management Response:

With this directive in mind the Marketing/Strategy and Planning Committee at WINN, Ft. Stewart, undertook a Staff Perception and Satisfaction Survey (Document #20a). Of the 855 surveys sent out to health care providers, 388 or 45% were returned. Graphs with correlated negative, positive and neutral responses of officers (Document #20b), enlisted (Document #20c), and civilian personnel (Document #20d) were constructed. Comments on the questions were solicited and recorded. Unfortunately, the original questionnaires were destroyed but available information gleaned from the original questionnaires was turned over to the WRAIR/UF research group for further analysis.

The WRAIR/UF research team suggests that the question formulation did not sufficiently address the central concerns of the MEDDAC Command Suite. While individual open ended responses obtained did shed some light on actual and potential sources of provider dissatisfaction, the information obtained is based on too small a response rate (45%). Given these constraints the available information can only have limited applicability for decision making. Because we cannot generalize the findings the best source of information about what actions may be needed to remedy perceived or actual provider problem areas may be obtainable from a careful re-examination of the body of answers to open ended questions. In essence, those responding to the quantitatively coded items followed the rule of safety in answering with a generally positive response. In general, the responses provide independent evidence of a local system-wide concern among providers that new solutions to Army family health care delivery must be found.

C. Overview of Findings Based on MEDDAC Survey Instrument:

Despite the constraints of the data generation process, our provisional analysis of the quantitative part of the internal document initiated by the Commander suggests that out of twenty-five questions, numbers 1,2,3,4,5,8,9,16,17, and 21 address organizational concerns having to do with the working unit; numbers 6,7,12,15,19,22,24, and 25 address organizational questions regarding the structure of the whole system; numbers 10,11,13,14,18,20, and 23 address the personnel concerns of providers. In all three categories average overall scores were slightly positive. However, in all three categories: 1.) concern over working unit organization, 2.) concern over the Ft. Stewart health care system as a whole, and 3.) provider/clinic staff satisfaction, civilian providers were more positive than officers and enlisted soldiers were less positive than either civilians or officers. Questions 8,9, and 10, which all had the word "boss" in them were the only questions answered in a "very" positive mode by all three groups. There was some concern recorded in the minutes of the Marketing/Strategy and Planning Committee Meeting of 24 June 1988 that "some comments were made that because the survey is coded, it's not anonymous."

As noted in the minutes of the Marketing/Strategy Committee report of 28 April, questions numbered 1 through 5, 12, and 21 through 25 received negative responses from all three groups, i.e., Officer, Enlisted and Civilian personnel.

There is a space on the questionnaire for comments beside each close-ended question. Most of these comments on the quantitative survey questions were extremely negative. However, there were so few comments that only tentative conclusions can be drawn. A major problem referred to by most respondents who did make comments seems to be poor morale because of failure of communication between officers and enlisted personnel, Army and civilian personnel, staff and their immediate supervisors, and between health care personnel and the Command Suite.

Some providers appear to perceive that they are unjustly criticized and seldom rewarded for the work they do. Some respondents suggest that there is chaos and confusion throughout the entire organization. They feel that the Command Suite is out of touch with the day to day problems providers must confront. Other respondents portray management at every level in the organization as trying to "look" good rather than trying to "do" good. Most of the providers who chose to comment on the quantitative survey questions when asked the question, "How do you think the community perceives you" answered they are either unaware of the reaction of the community to their health care efforts or they perceive the community response as negative. The majority of respondents who commented on the closed ended survey questions were discontented and unhappy with their work and with their entire living/working milieu. When asked about what value they thought the survey would have, most replied that the survey would only have value if the information was disseminated and changes were made. Again, it must be emphasized that the majority of providers answering the questionnaire chose not to comment on the closed ended questions.

The WRAIR/UF research team is presently analyzing the open ended questions on the survey. All information will be forwarded to Commander Garcia at Ft. Stewart.

STAFF PERCEPTION AND SATISFACTION SURVEY

DEMOGRAPHIC DATA

Officer _____

Enlisted _____

Civilian _____

PLEASE RATE THE FOLLOWING STATEMENTS BY CIRCLING THE NUMBER THAT MOST CLOSELY EXPRESSES YOUR OPINION, WITH A "1" RATED AS "STRONGLY DISAGREE" AND A "5" AS "STRONGLY AGREE" COMMENT AS DESIRED.

<u>Statement</u>	<u>Rating</u>					<u>Comments (Optional)</u>
	STRONGLY DISAGREE/STRONGLY AGREE					
	1	2	3	4	5	
1. Morale is good.						_____
2. Communication is good.						_____
3. Micromanagement seldom occurs.						_____
4. Teamwork is good.						_____
5. People are recognized and rewarded well.						_____
6. The Command Group (COL Garcia and staff) is supportive.						_____
7. The Command Group (COL Garcia and staff) is proud of us.						_____
8. My boss is supportive.						_____
9. My boss is competent						_____
10. I feel respect for my boss.						_____
11. I am treated with fairness.						_____
12. This is an excellent organization						_____

Encl 1

STAFF PERCEPTION AND SATISFACTION SURVEY

PAGE

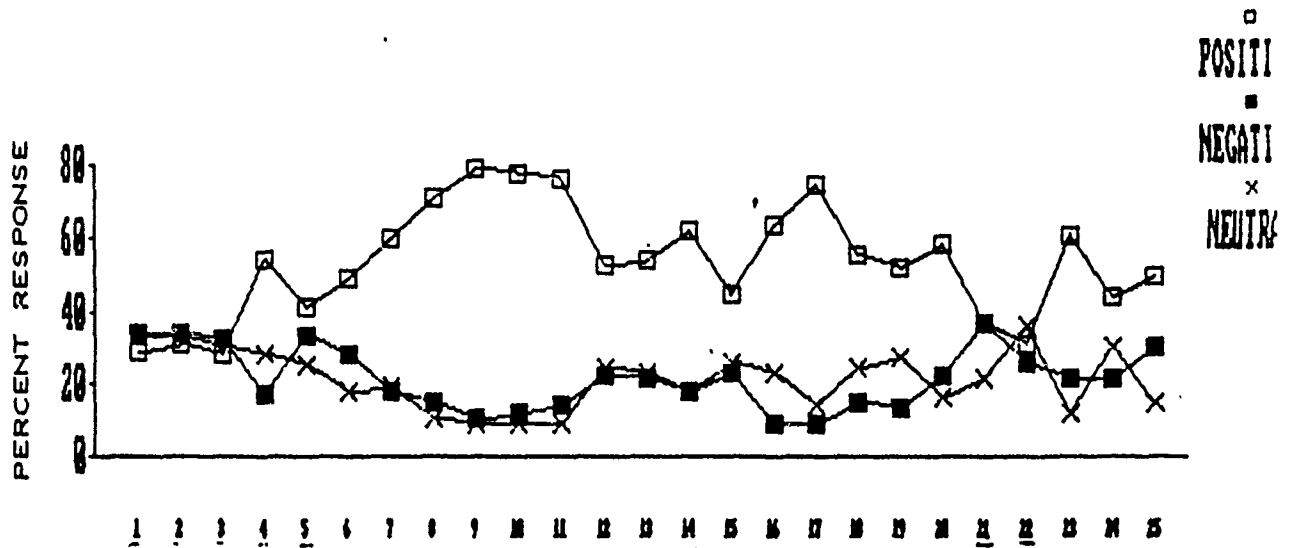
Statement	Rating					Comments (Optional)
	STRONGLY DISAGREE/STRONGLY AGREE					
13. I have a lot of job satisfaction	1	2	3	4	5	
14. I am proud of this organization.	1	2	3	4	5	
15. This is a well-run organization.	1	2	3	4	5	
16. Employees are friendly.	1	2	3	4	5	
17. We provide good care and services.	1	2	3	4	5	
18. I like working here.	1	2	3	4	5	
19. This is a good survey.	1	2	3	4	5	
20. I am treated with dignity and respect.	1	2	3	4	5	
21. My co-workers are happy.	1	2	3	4	5	
22. The community is proud of us.	1	2	3	4	5	
23. I like being stationed/living here.	1	2	3	4	5	
24. Departments and services interact well.	1	2	3	4	5	
25. The chain of command is responsive to my needs.	1	2	3	4	5	

PLEASE ANSWER THE FOLLOWING QUESTIONS AS HONESTLY AS POSSIBLE. FEEL FREE TO ATTACH CONTINUATION SHEETS AS NEEDED.

1. How well do you think things work in this place?

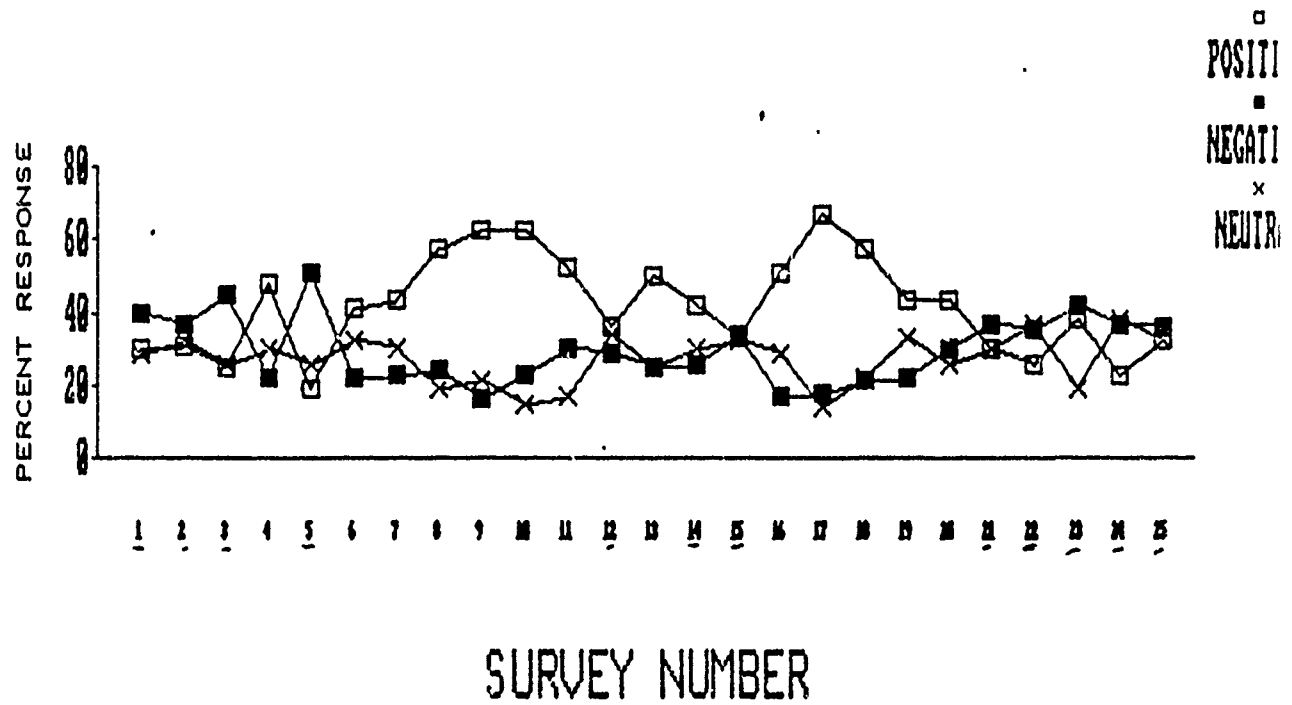
2. Do you feel like you know what's going on around here? Yes No (Circle One)
 "No", why not?

OFFICER RESPONSES

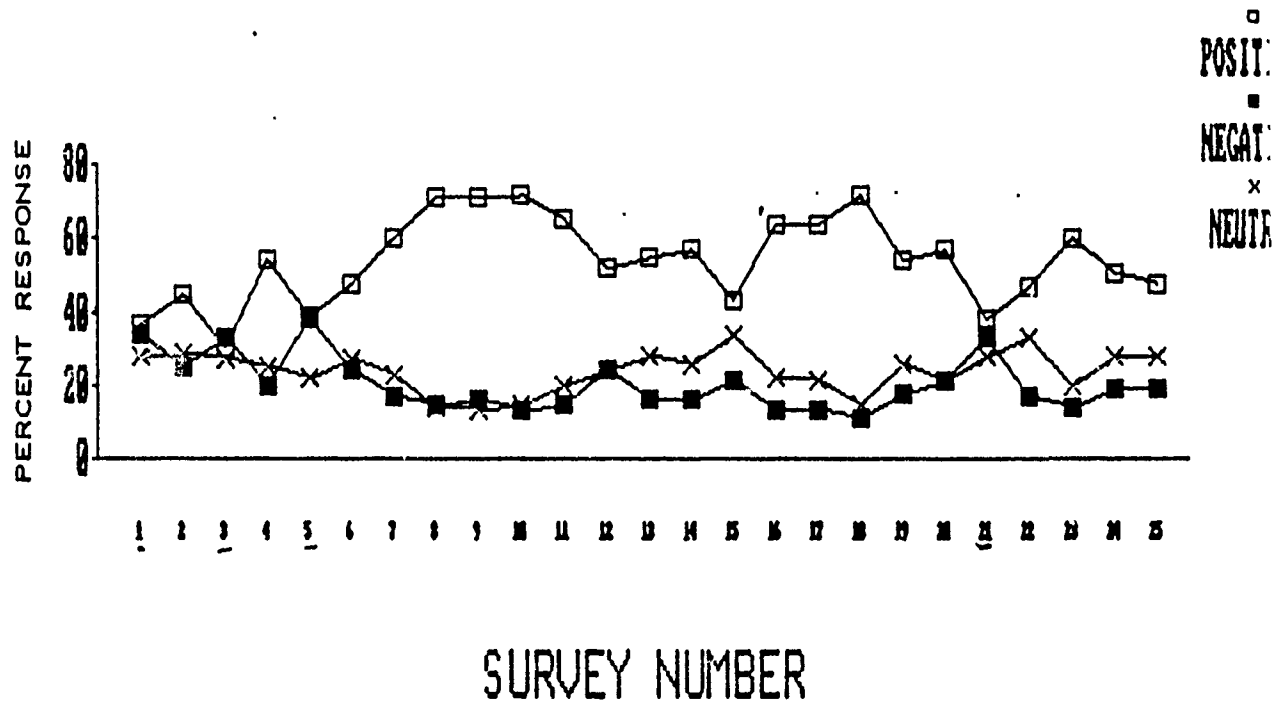


SURVEY NUMBER

ENLISTED RESPONSES



CIVILIAN RESPONSES



Major Categories for Army Times Newspaper Articles

1. AIDS RELATED ISSUES
2. BUDGET ISSUES RELATED
3. CHAMPUS REFORM
4. DISABILITY, MALPRACTICE, AND COMPENSATION ISSUES AND CASES
5. ENVIRONMENTAL HEALTH
6. FT. STEWART AND HUNTER-POST RELATED MEDICAL INFORMATION
7. GENERAL NEWS AND ISSUES
8. HEALTH STATUS OF MILITARY
9. INNOVATIONS AND IMPROVEMENTS IN HEALTH CARE
10. MILITARY FAMILY ISSUES
11. HEALTH CARE FOR RETIREES
12. SELF-CARE AND HEALTH AWARENESS INFORMATION
13. STAFFING AND PERSONNEL ISSUES IN ARMY HEALTH CARE
14. WOMEN AND MINORITIES

**Preliminary Content Analysis of the Titles
of Army Times Articles**

- I. AIDS RELATED
 - A. Patient/Provider Issues
 - 1) Handling of infected patients
 - 2) Hazardous pay
 - B. AIDS Education Efforts
 - C. VA AIDS Programs
 - D. Drugs for AIDS Patients
 - E. AIDS among Reservists
 - F. AIDS Litigation Procedures
 - G. Effect of AIDS on Military Readiness
 - H. General Epidemiological Concerns Regarding AIDS
- II. Budget Issues Related to Military Medicine
 - A. Funding of Off-Base Health Care
 - B. Budget Cuts Affecting Military Health Care of Active Soldiers and Their Dependents
 - C. Effects of Budget Induced Provider Shortages on Quality of Health Care
 - D. VA Budget Cuts
 - E. Effects of Budget Decisions on Military Retiree Health Care
 - F. Enactment of Medical Care User Fees and Their Effect on Military Health Care
- III. Champus Reform
 - A. Effects of Champus on Retirees and Military Dependents
 - B. Liquidity of Champus
 - C. Fee/Cost Issues
 - D. Comparative Insurance Plans
 - E. Extent of Champus Coverage
 - F. Eligibility
 - G. Availability
 - H. Handling of Claims
 - I. Regional Issues
- IV. Disability, Malpractice, and Compensation Issues and Cases
 - A. Compensation and Claims on Behalf of Dependents of Active Duty Personnel
 - B. Agent Orange Benefits and Litigation
 - C. Malpractice Claims and Rights
 - D. Reservists' Compensation and Claims
 - E. Determination of Disability Status
- V. Environmental Health Issues
 - A. Pollution of Water and Air on Army Bases
 - B. Impact of Military Activities on the Civilian Environment
 - C. Dangers of Toxins such as Dioxin, Radon and Lead

- VI. Ft. Stewart/Hunter Post Related Issues
 - A. Family Problems on Base
 - B. Fitness Center Policies
 - C. Physician Shortages
 - D. Emergency Team Competency
 - E. Accreditation of Clinic Laboratories
 - F. DENTAC Staffing
- VII. General News and Issues
 - A. Comparative Care Standards in Military and Civilian Hospitals
 - B. Threats to Military Health Care Benefits
 - C. The Aging of the Military Force
 - D. The Percentage of Women in the Military Service
 - E. Volunteers in the Health Service
 - F. VA Hospital Bed Shortages
- VIII. Health Status of the Military
 - A. General Epidemiological Information
 - B. Smoking Problems
 - C. Weight Problems
 - D. Alcohol Related Problems
- IX. Innovation and Improvements in Health Care
 - A. More Emphasis on Physical Fitness
 - B. Screening and Testing Procedures
 - C. Nutritional Status and Dissemination of Nutritional Information
 - D. Regional Improvements in Health Care Approaches
 - E. Improved Technology in DENTAC and MEDDAC Installations
 - F. Alcohol Rehabilitation, Prevention, and Testing
 - G. Hospice Availability
 - H. More Sensitivity to Family Issues and General Improvement in Family Medical Care
- X. Staffing and Personnel Issues
 - A. Effects of Adequate Health Care
 - B. Concerns of Nurses
 - C. Status/Background Checks on Professionals
 - D. Staff Shortages
 - E. Reserve Medical Specialists
 - F. Pay Issues for Professionals
 - G. Day Care for Medical Staff Children
 - H. Uniforms
 - I. Promotion Issues
 - J. Wartime Draft of Doctors and Nurses
 - K. Questions Relating to Physician Assistants
- XI. Women and Minorities in the Military
 - A. Effect of Pregnancy on Readiness
 - B. Career Opportunities for Women in the Military
 - C. Quality of Military Health Care for Women
 - D. Status of Minorities in the Military

XII. Military Family Issues

- A. Family Stability
- B. Stress Related Events
- C. Army Reserve Family Issues
- D. Child Care
- E. Family Health Options

XIII. Health Care for Retirees and Retirement Benefits

- A. Stress-Related Retirement Benefits
- B. Closings of Military Hospitals and Clinics
- C. Health Care Taxes
- D. VA Hospital Closings
- E. Physical Fitness for Retirees

XIV. Self-Care and Health Awareness

- A. Cholesterol Screening
- B. Smoking Issues
- C. Proper Dental Care
- D. Disease Prevention Strategies
 - 1) Self-exams
 - 2) Monitor Sunlight
 - 3) Monitor Caffeine Intake
 - 4) Exercise Programs
 - 5) Heart check-ups
 - 6) Cholesterol checks
 - 7) weight control
 - 8) nutritional awareness
 - 9) blood pressure checks

ABSTRACT

DeFrieze, G. H.

1987 The Role and Significance of Medical Care Research.
Journal of Internal Medicine 2:131-133.

DeFrieze presents a very brief "state of the art" editorial on medical care or health services research. Though such work began in the late 1920's, it has grown very rapidly in the last twenty years, and there are now more than 2,000 professionals in the field, working in a wide variety of disciplines. There are more than 40 university-based centers or institutes for health services research or health policy analysis in major academic institutions. The National Center for Health Services Research and Health Care Technology (NCHSR/HCTA) has existed for twenty years as a formal unit within the U.S. Public Health Service.

In justifying increased support for health services research, DeFrieze believes it is important to develop good understanding of the role and utility of such research in the broader context of American health care: "What is needed is a foundation of research that can provide a thorough understanding of the way in which the characteristics of the system of care delivery, the characteristics of the patient (and family situation), the skills of the physician, or the process through which care is provided can influence and determine clinical outcomes and patient satisfaction"(132).

Also, health services research can provide "a means for acquiring a framework for understanding the factors that influence patterns of health care use, and therefore may contribute to our understanding of ways in which access to care may have impact on health status"(132). Factors influencing health services use are extent of acuity of illness symptoms, sociodemographic characteristics of the client, accessibility of physician and other health care providers, and the organization and financing of health care services.

DeFrieze's editorial is also partly a response to recommendations made by Shapiro and Larson (1987, also on our bibliography) for funding for medical care research. The latter authors called for substantial budgetary increases to the NCHSR/HCTA for such research. DeFrieze contends Shapiro and Larson oversimplify a very complex situation, and that it is inaccurate to summarize current financial support based on reference to the budgets of one or two Federal agencies. He is also critical of Shapiro and Larson's recommendation for increased advocacy effort in behalf of increased federal budgetary support, saying the authors fail to make clear the current existence of a strong and stable advocacy organization for this purpose -- the Association for Health Services Research (AHSR), and that efforts should be made to bolster and support this lobbying group rather than forming new ones.

NOTES AND QUERIES

DeFrieze, G. H.

1987 The Role and Significance of Medical Care Research.
 Journal of Internal Medicine 2:131-133.

1. What proportion of its budget does the military spend on health care services? At what level of decision-making are these allocations made (e.g. within military itself or at federal levels?)

2. Can we get hold of any kind of bibliography of health care research projects done through WRAIR? Has NCHSR/HCTA done any studies of military health care services, or other pertinent research? Should we try to find out and locate it?

3. Are there any clubs, groups, organizations of military personnel and/or dependents, retirees that have made any kind of lobbying efforts for improved health care services? How do we find out?

ABSTRACT

Speigel, J. S., et. al.

1984 Consequences of Variation in Definition of the
Primary Care Physician. Santa Monica, Ca.: The Rand Corp

This article describes a study done to determine "whether three methods of defining a primary care physician would result in different proportions of generalists and specialists being designated primary care physicians"(2). The researchers' aim was to examine the validity of several studies which defined the 'specialist' as the primary care physician if she/he provided the "majority of care." With this limited definition, the authors hypothesized that the contribution of specialists to provision of primary care may have been overestimated. They used two additional definitions of "primary care physician" in their study: 1. the physician who was designated to receive results of a multiphasic screening exam, 2. the physician who treated common problems.

The authors used screening examination and insurance claim form data from 2752 people enrolled in a health insurance company in three different kinds of communities (rural, small metropolitan area, moderate-sized city). 1620 people were randomly chosen to receive multiphasic screening exams and the physician to whom results were requested to be sent by patient were recorded. Also, during the experiment period of one year, each person was required to complete an insurance claim form each time a physician was seen or a medical service of any type completed.

It was found that only 1 out of 10 people identified a specialist to receive results of screening exams (12% specialists). Common conditions studied were upper respiratory tract infections, hypertension, and general exams, and only 1 out of 10 people used specialists for these complaints (9% specialists). However, when the primary care physician was defined as the physician providing "majority of care," 34% were specialists. Thus, the number of physicians designated as primary care physicians varies with the definition used.

The researchers compared their methodology and findings with other studies of primary care which used the "majority of care" definition and which used data from physician survey responses and physician reports. Results varied. The authors are critical of such studies based solely on physician response and state, "when identifying a primary care physician, researchers should pay attention to the patient's perception of who functions as their primary physician, and to the tasks frequently associated with primary care, such as care for common problems and health maintenance"(11-12). Such information would be useful in determining if too many specialists are being trained and to compare the cost, quality and outcomes of primary care delivered by physicians with various types of training.

Possible limitations of the study were discussed: a smaller number of physicians than other studies used, exclusion of a large metropolitan area as a study location, exclusion of people aged 62 and over, and the time limitation of one year.

NOTES AND QUERIES

Speigel, J. S., et al.

1984 Consequences of Variation in Definition of the
Primary Care Physician. Santa Monica, Ca.:
The Rand Corporation.

1. This article reminds us to examine our definitions and concepts and to be very wary of how these may affect results, how varying definitions may cause different results.

2. The authors set a good example by discussing possible limitations to their study, holes in methodology, etc. ... they provide a critical evaluation of their work and its' drawbacks, applications. We should mutually explore and discuss limitations to our research methodology as we proceed and try to determine effects on outcomes ... e.g. ... how does age/sex of interviewer affect client response -- is there some way we can document this as we go along?

3. What is the ratio of specialist and generalist physicians in the clinics we will be studying? What is the average age, training of the physicians in the study group? Do clients have more confidence in, preference for, particular kinds of physicians?

Further Methodological Considerations Pertaining to Mail Survey

A. Sampling Frame:

The minimum number of sites is one-- Ft. Stewart/Hunter AAF. We have extensive field and survey data at this site and the mail survey would complement it well. The maximum number of sites is three-- Stewart plus two others. More than a total of three sites would mean a very small number of respondents at each site, given size limits imposed by budget. In addition, it is unlikely that we could gather field data required to provide social context for the survey at more than two sites. In addition, though David Marlowe can address this point better than we, the effort and time required to get local permission to conduct the survey and access to the post mail system probably limits us to no more than two additional sites.

At each site, we would ideally draw a sample of the population with DEERS eligibility, though it may be necessary to settle for a sample from the AD roster. If so, we would probably want to exclude single persons who live in the barracks. While they can justifiably be included in a study of Army Health Care over the life course, the large number of them-- about half AD enlisted-- would overwhelm our limited resources and prevent us from saying much about families. This was much less of a problem in the clinic interviews, because most unmarried AD use only the TMC which was not an interview site.

We probably want to start out with mailing out 1500 mail surveys, with the distribution across sites proportional to their size. The best way to distribute the mail survey is through the post mail system. We will include a self-addressed business reply envelope for the surveys to be returned directly to us by U.S. Mail. The AD soldier or an adult dependent could complete the survey.

The issues of drawing a sample and using post mail are ones that will require discussion with David Marlowe.

B. Identification of Respondents

A remaining methodological issue is one of identification of respondents. The Dillman technique originally proposed requires that there be a way of identifying who has returned the mail surveys in order to allow economical follow-up mailings. One way we could do this is by having a number on the return envelope. Opening the returned mail would separate the control number from the survey, providing anonymity for respondents. This may raise some human subjects concerns as well as concerns by respondents. We want to consider explaining it in the letter to respondents to be sent with the survey.

Tentative Schedule of Target Dates for Mail Survey Process:

- by September 30: Begin selection of sites; take initial steps to gain access to samples at each selected site.
- by December 31: Mail-out is underway at Ft. Stewart. Completion of initial one- to two-day visits to additional sites by Otto and David Marlowe is anticipated.
- by February 5: Three- to four-day visits to additional sites by UF team.
- by March 5: Mail-out underway at other sites.
- by April 5: Mail-out surveys completed.

Center for Gerontological Studies

M E M O R A N D U M

Univ
of Fi

TO: Gene Hemp
Provost Pro Tem

FROM: Otto von Mering and Lois Randolph *LBR*

DATE: June 6, 1989

SUBJECT: Status Review of WRAIR sponsored research Army Family Health Seeking Behavior Satisfaction

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Dir.

In a May 16, 1989 interview with the Army Times Defense Secretary Richard Cheney stated, "I will do everything I can to fend off efforts by Congress to put weapons systems back in the budget or to keep bases open at the expense of quality-of-life issues." He pointed out that a variety of economic and demographic factors may make it harder for the military to recruit and retain good people in the future.

The declining population of 18-year-olds from which to recruit and a full employment economy making military service a less attractive career option are two such factors. The gap between military and civilian pay has grown to 11% in the last decade. Quality-of-life factors are becoming increasingly important in the recruitment, retention and readiness of those serving in the Armed Forces. This realization transcends the special interests of particular branches of the military service.

An ongoing WRAIR/UF-CGS Research Project on Army Family Health Seeking Behavior Satisfaction concentrates specifically on the Army health care system, a major quality-of-life issue among military families. The research is examining the nature of day-to-day interactions between Army families and the military health care system associated with the effective use of health care. It attempts to identify the sources of satisfaction and dissatisfaction with the health care services and assess the impact on health care utilization, recruitment, reenlistment and readiness for military action.

The WRAIR/UF research project was initiated in June of 1987. Sites selected for the research were Ft. Stewart in Hinesville, Georgia, Hunter Army Air Base in Savannah, Georgia, and the Primus primary care clinic in Savannah, Georgia. The three central foci in the project concern: 1) Provider-Client transactions; 2) Self-Care; and 3) the Life Course perspective.

Provider-Client Transactions

Effective communication between provider and client and expectations, perceptions and satisfaction of both provider and client combine to make a beneficial or negative health care experience. Primary health care consumer segments considered as subjects for the research include active duty personnel, their family members, retirees, and health care providers both civilian and military, at all levels of ambulatory care giving.

The WRAIR/UF project seeks to delineate and document the characteristic patterning of client, provider, and organizational factors that lead to satisfaction or dissatisfaction with the delivery of military health care to the Army family. Significant issues which address client/provider transactions include the ways and means of patient handling or "processing" into and within the care system, and how they affect patient satisfaction. The efficiency-versus-quality-care issue under the constraints of rotating Army personnel and normative hierarchical administrative practices are also addressed. Concurrently, the client and provider peer group influences on expectations and perceptions of health service delivery are explored.

Self-Care

An OTA Report in June, 1988, states: "The issue of how well organizations use, and how well they communicate quality care information to their health professionals and clients remains essentially unexplored." The present WRAIR/UF research is examining the provider/client transactions regarding the acquisition and use of information related to self-care. Self-care in this context is defined as the individual's initiative to comprehend health issues and to take responsibility for personal well-being. This includes the cognitive organization of care or being one's own "case manager" in regard to general knowledge about health conditions.

A "well-being-competent" Army family is one which has acquired the know how to make prudent choices about the health care of its individual members. This research examines to what extent this occurs among the Army families at the sites selected for the study. Health care professionals have a key role in the dissemination and acceptance of preventive self-care knowledge. This research investigates how providers perform that role.

People are looked at both as patients in need of curative medical services and as clients who seek preventative health information. The dependent or "not self-care" concept is juxtaposed to independent self-care and effective handling. Information on how well the Army medical system has initiated early detection, self-help and preventive practices at the particular study sites will be explored through the data obtained by the interviews with both Army families and health care providers.

Life-Course Perspective

Life course refers to the patterning of age, marital status, number and age of children, spousal work status and career stage found among people in every Army community. The Army consists of the same diversity of family types found in the civilian population. The WRAIR/UF project seeks to relate differences in effective use of medical care to the variety of Army families. The anticipated findings will reflect the role of the diversity of family types across the life course and the role of provider promotion of an active family stance toward understanding and taking responsibility for one's health.

Some of the key questions posed by the intensive interview research instrument seek to determine what differences exist between Army families who actively participate in their medical care and those who do not. Which families use readily available health care knowledge and which families routinely defer to an expert in the case of sudden illness? Which families are well-served by military medical care practices? How is effective care promoted for different families, and how can individual behavior patterns and the organization of hospitals and clinics be altered to facilitate better health care?

The above questions are addressed in the research and analyzed using the life course perspective as a theoretical base. Central to the life course approach is the salient fact that the development of the all-volunteer Army has both increased the diversity of family types and increased the importance of "fringe benefit" programs such as medical care for recruitment, retention, and readiness of men and women serving in the Army Forces.

Research Methodology

Three major research strategies distinguish this project from similar studies of health care organizations: 1) systematic attention to both organizational structure and client and provider behavior; 2) consideration of preventive and curative approaches found in the organizational structure and client/provider expectancies; 3) recognition of the self versus non-self paradigm which is manifested in the form of self-handling, care giving and supportive behavior. Particular aspects of the health services covered include: 1) general patient care issues; 2) military health actualities; 3) comparisons of military/civilian health service delivery policies; 4) patient treatment/patient "handling" continuities of care-giving and management; 5) health promotion including disease prevention patterns; 6) local health service command, communication, and clinic organization styles and; 7) general professional development opportunities for providers and the climate in the work place.

Data Collection

Data have been collected at the three sites mentioned previously. Research questions have been pursued through a two-pronged strategy: a) a study of particular interactions combined with survey interviews in a sample of clinic users (N=801) and providers (N=201) and; b) a mail survey of a sample (N=1000) of the population of all healthcare eligible persons including potential and actual health care seekers and users within a defined geographical or catchment area.

A mail survey is indicated as a clinic-user study alone would not suffice since low clinic users would be underrepresented. The clinic user study component provides more intensive interview data, while the general survey focuses on overall care perceptions and satisfaction. The clinic user component concentrates on specific health care encounters, while the survey portion provides information on general behavioral aspects of encounters and patient perceptions of their encounters. In addition to the analysis of clinic data obtained through intensive interview procedures and the survey sampling instrument, researchers are also examining meeting notes of four key WINN Community hospital management and advisory committees, as well as health system-related articles which appeared in the Army Times during the designated period of the research activity.

Research Model

The WRAIR/UF research model is a multi-faceted, "grounded" research design reflecting the interdependence of satisfaction, services and expectations. Both quantitative and qualitative research analytical techniques are employed. This allows the researcher to do systematic cross-referencing of quantitative findings and qualitative interpretations arrived at through data analysis.

Complete reliance on mathematical regulatory or management information models, which has often been the research approach employed in the study of health care systems, cannot foresee particular utilization and satisfaction consequences related to the introduction of structural change or organizational additions such as the privatisation of certain portions of military health care. Exclusive use of these models generates hypotheses which are broad "average" approximations of reality; certain members of the population such as retirees may be "lost." Since there is a significant segmentation of the "average" health care user and provider, more time-consuming and alternative investigative routes have to be followed if the model is to correctly represent the entire population participating in the health care system.

Status of the Research at the Present Time

Major project events have included planning, data collection, data analysis, and report preparation. Presently, two teams of researchers are analyzing a data base consisting of a completed total of 801 client interviews and 196 currently finished provider interviews, collected at the three designated sites. The team concentrating on quantitative analysis is employing simple univariate statistics and multiple regression procedures. The data set coded from the client satisfaction interviews has been "cleaned" of all invalid or "illegal" data punches indicated by the Statistical Analysis System (SAS), corrected by recoding the invalid data using the original questionnaires. Using frequency counts, all out-of bound or improbable data punches have been investigated and corrected. The consistency of the data set has also been checked through the use of bivariate relationships (cross-tabulations) to determine whether appropriate questions were answered by certain categories of respondents. Presently a new SAS data set is being constructed to examine one of the central research ideas concerning the different life course characteristics of the interviewees.

The team working on the qualitative data are using content analysis procedures to derive major themes from the interviews and fieldnotes. A coding manual and tally sheet are being written. There will be three levels of analysis based on thirty open-ended questions out of a total of 45 contained in the client interview, the meeting notes of the four WINN hospital committees, and relevant articles collected over a two-year period from the Army Times. General themes derived from this set of data will be the basis on which to identify, cross-tabulate and measure salient thematic content.

Principal themes derived from the data at this time include "Self/Not Self Care/Self-Efficacy orientation"; "Expectation/Limitation of Treatment-Service Outcomes"; "Communication/Information Seeking"; and "Inequalities/Equalities in Care/Access to Care." Further refinements have produced sub-themes relating to Expectancies of Competence for Self/Not Self Care, Expectancies of Limitations in Health Care Service Delivery, Perceived Inequalities in Care and Access to Care and Perceived Conclusions of Support/Non-Support of the Army Family. Further refinements of the data base are in process.

The mail survey is being constructed at present. It will be used to reach more 'subjects' than those at the original sites, and will extend the total research data base to two additional sites in the United States. The locus of these Army Community clinic sites will be determined in consultation with WRAIR staff. The survey will use a short version of the interview content used for clients and providers in the clinics. Only those questions will be included in the mail survey form which have produced the most telling results. In other words, the most "powerful" question items from the previous interviews will make up the mail survey.

Applicability of the Results of the Research

The overall applied goal of this basic research is to prepare and supply useful information to Army Health Service Command and MEDDAC and DENTAC units which may enable them to:

- 1) predict local consequences of systemwide changes in health care delivery;
- 2) develop recommendations for programs that effectively deal with the identified sources of dissatisfaction which may be contributory to readiness and retention;
- 3) develop recommendations to improve the effective utilization of primary medical care among diverse Army families and to improve its management by the principal care providers;
- 4) facilitate clinic/provider promotion of health care activities and dissemination of self-care information to clients including life style management programs which may encourage Army families to augment their understanding and taking responsibility for their health;

- 5) initiate leadership training programs for health care providers and company commanders;
- 6) transfer the value of what we learn about health care in the Army to other branches of the Armed Services and the health care data bank of the larger civilian population;
- 7) implement cost savings through improving the use of health care facilities and reducing the need for health care services through health promotion programs.

By concentrating on well-being programs, the Army Community Service program in concert with MEDDAC personnel could become more effective. By placing an interdependent emphasis on preventive as well as curative health measures through health promotion and disease prevention services, the need for emergency and highly specialized tertiary medical health care may be greatly reduced, resulting in lower cost and higher satisfaction with the health care system on the part of both clients and providers.

Relevance of the WRAIR/UF Research Project to Navy Health Care

The significance of what will be learned from this project concerning the Army health care system has transfer value for assessing the status and future of Navy health care. The Navy Blue Ribbon Panel established in May of 1988 and headed by Dr. James A. Zimble, Surgeon General of the Navy and Director of Naval Medicine, formed conclusions regarding the structure of the Navy medical system which mesh closely with the research questions our present WRAIR/UF project is addressing. Central to this report was the need for patient-provider relationships to be studied on an individual level. Also suggested was improved management, increased accountability for personnel and dollar resources and an effort to reduce CHAMPUS costs by returning patients to Navy hospitals.

These are also some of the same issues addressed by the WRAIR/UF ongoing project investigating health care among Army families. The specific recommendations handed down by the Navy panel echoed two major goals of the current WRAIR/UF research: 1) to guide future Army health care policy decision making; 2) to prepare new basic instructional materials for active duty personnel. By the end of 1989, the present data generation phase is coming to a close. Starting in 1990, formal data analysis and dissemination of findings will take place.

It is our belief that we have constructed a research design for a type of investigative study that can be initiated at a reduced cost in the future. This model of health care evaluation research could easily be transferred to other military installations. Having examined closely the Navy Blue Ribbon Panel Report we suggest that the current WRAIR/UF research effort toward achieving a "civilian" solution to the special "military" problem of providing sound and lasting Army family health care with cost-efficiency is also usable with the Navy health care system. We further suggest that the studies conducted on military health care may contribute to the natural dialogue being generated on health care throughout the life course of the entire population, both military and civilian.

MEMORANDUM

TO: Dr. Otto Von Mering
FROM: Lois Bright Randolph
DATE: July 25, 1989
RE: Chronology of Preparatory Site Visits

Chronology of Preparatory Site Visits of The Principal Investigators of the WRAIR/UF Research Project on Army Family Health Seeking Behavior Satisfaction

The following chronology of preparatory site visits to Ft. Stewart, Hunter Air Force Base and Primus-Savannah, Georgia from March 1987 to December 1987 is a supplementary document prepared as part of a review of the field observations of Dr. Otto Von Mering, the principal investigator, and Dr. John Henretta, the co-investigator, of the WRAIR/UF research project investigating Army family health seeking behavior satisfaction. Activities included: 1) meetings with the MEDDAC Commander Juan Garcia, MC; 2) meetings with members of the Army Health Service Command; 3) visits to MEDDAC and DENTAC units including TMC's, battalion aid stations, specialty clinics, the base hospital, the emergency room clinic, and PRIMUS; 4) visits to Army Community Services; 5) attendance at WINN Committee meetings. Dr. Von Mering and Dr. Henretta also had conferences at Fort Stewart with the Quality Assurance Coordinator, the Internal Auditor, the Patient Representative, Chief of the Clinical Support Division, Chief of the Emergency Medical Services, Chief of the Social Work Service, Chief of the Patient Administration Division, the Health Benefits Advisor, and Chief of the Personnel Division.

From these site visits and briefing sessions with many other Army health care personnel Dr. Von Mering compiled copious field notes. These field notes were utilized in the decision making process leading to the structure of the overall study. The observations were also used as material for instructional memos for the WRAIR/UF research study group. Most importantly, they provided information necessary for the design and construction of the client/provider interview instruments.

Chronology of "Issue and Problem Familiarization" Site Visits: March 1987 to December 1987.

15 March 1987

Introductory site visit to Ft. Stewart-MEDDAC with Dr. David Marlowe, and orientation meetings on WRAIR/UF research project.

12 June 1987

Meetings from 0730 to 1500

LTC Gary Bennett, Comptroller
MAJ Richard Keagle, Logistics
MAJ Steve Bottaro, Pharmacy
CPT Susan Walantas, Nutrition Care
MAJ Peter Leventis, Personnel
MAJ Joan Dunlap, Preventive Medicine
CPT Gaston Randolph, Patient Administration
COL Mary Chadwick, Department of Nursing
Dr. Paula Lang, Ph.D, Drug and Alcohol Prevention/Control
Commander's Marketing/Strategy and Planning Committee Meeting
Mrs. Sarah Eldridge, Commander's Office
CSM Henry Chambers, Command Sergeant Major
Joyce Nee Smith, Information Management Division

15 July 1987

Meetings from 1430 to 1630:

COM Juan Garcia
Mrs. Jean Beatie, Quality Assurance Coordinator
Mrs. Ruth Darling, Internal Auditor
Col Donald Helin, Deputy Commander for Administration

16 July 1987

Meetings from 0800 to 1630

LTC Stephen Gibbs, Chief, Department of Primary Care and
Community Medicine
Mrs Nellie Nelson, Patient Representative
MAJ Douglas Miller, Chief, Clinical Support Division
Dr. Paula Lang, Clinical Director, Drug and Alcohol
Mrs. Joyce NeeSmith, Chief, Information Management Division
COL Joseph DiLuciano, Deputy Commander for Clinical Services
LTC Wilfred Souffrant, Chief, Internal Medicine Service
LTC Ibrahim, Chief, Pediatric Service
MAJ Joseph Lawrence, Chief, OB/GYN Service
MAJ Stephen McAlpine, Chief, Emergency Medical Services

MAJ Mark Cook, Chief, EENT Clinic
COL Garcia, MEDDAC Commander

17 July 1987

Meetings from 0800 to 1200

MAJ Thomas Schmitt, Chief, Social Work Service
CPT Gaston Randolph, Chief, Patient Administration Division
Mrs. Marcelene Swain, Health Benefits Adviser
LTC Harold Tarpley, Chief, Psychiatric Service
MAJ Peter Leventis, Chief, Personnel Division
MAJ Samuel Bottaro, Chief, Pharmacy Service

11 August 1987

Meetings from 1330 to 1600

COL Garcia/LTC Martin
Gary Smith, Resource Management
ILT John Wingate, Administrative Support Division

12 August 1987

Meetings from 0830 to 1630

Dr. (MAJ) John Rosemond, Division Surgeon

LTC David Rolson

Visit to Battalion Aid Station

MAJ Cook, EENT

Mrs. Patricia Sharp and Mr. Robert Ray, Army Community Services

COL Chadwick

13 August 1987

Meetings from 0830 to 1600

Mrs. Joyce NeeSmith, Information Management Division

CPT Robert Jones, Plans and Fitness Training

SFC Jerry Cipolla

Joint Staff Meeting

Dr. (MAJ) Keith Hall, Psychiatry Service

14 August 1987

Meetings from 0800 to 1200

Tuttle Army Health Clinic

15 August 1987

Meetings from 1430 to 1630

Mrs. Beatie, Quality Assurance Coordinator

Mrs. Ruth Darling, Internal Auditor

8 September 1987

Meetings from 1300 to 1600

COL William L. Priddy, DENTAC Commander

COL Robert S. Boren, OIC Dental Clinic #1

9 September 1987

Meetings from 0900 to 1630

MAJ John Rosemond, M.D.

CWO Robert Rakosky at Battalion Aid Station

Dr. Perez at TMC#1

CPT Gaston M. Randolph, Jr., Chief, Patient Administration Division

MAJ Dorothy A. Brink, Department of Nursing Education and Training

SFC Tommie Sparks, RN Ed.

19 October 1987

Meetings from 0830 to 1500

CPT Missler, Tuttle Army Health Clinic

Mrs. Herndon, Health Benefits Advisor

20 October 1987

Meetings from 0830 to 1600

CPT Missler, Tuttle

Spent day at PRIMUS Clinic with Mr. Chappell and Staff

21 October 1987

Meetings from 0930 to 1300

Attended Hospital Advisory Committee at WACH, WINN
COL Juan Garcia

9 November 1987

Meetings from 1100 to 1600

COL Helin
MAJ Peter Leventis
MAJ Bottero
CPT Randolph

10 November 1987

Meetings from 0830 to 0600

CPT Missler
MAS Edwina Murdock
Debriefings with George Chappell and H.C. Williamson

8 December 1987

Meetings from 1100 to 1700

MAJ Doug Miller
MAJ Keagle
CPT Robert Benson
COL Priddy

9 December 1987

Meetings from 0800 to 1900

CPT Missler to interview the Ranger physicians
Health Care Consumer Committee Meeting
COL Helin
Mr. George Chappell

Me. J:

To: Otto von Mering

From: Betty Goodson

Date: 7/27/89

Subject: Invoice and Disbursement records for period 1/16/89 to 6/9/89 for WRAIR contract-related interviewing services performed by temporary employees Bonnie Coats and Joan McTigue.

DOCUMENT #29

Joan McTigue

SITE VISIT DATES: 1/16 1/27 2/9 2/10 2/26 3/8 3/9 3/10
(initial training series) (Ft. Stewart-MEDDAC)
2 2.5 3.5 10.5 2 3.75 8.75 3.75
Interview & travel hours
Total hours compensation 20.5 x \$25.00 = \$512.50 16.5 x \$25.00 = \$412.50
Invoice # & date submitted* 90493 3/31/89 113925 5/3/89
"UF Payables and Disbursements" \$119.90
Incidental Travel exp. reimb.- 02/13/89 03/15/89
Invoiced to UF Travel & Date

SITE VISIT DATES: 04/12 04/13 04/14 04/27 04/28
Interview & travel hours 3.75 8.0 12.75 3.75 10.75
Total hours compensation 24.5 x \$25.00 = \$600.00 14.5 x \$25.00 = \$362.50
Invoice # & date submitted* 113919 4/25/89 064486 05/31/89
"UF Payables and Disbursements" \$94.00
Incidental Travel exp. reimb.- 04/25/89 \$56.47
Invoiced to UF Travel & Date 05/16/89

SITE VISIT DATES: 05/31 06/01 06/07 06/08 06/09
Interview & travel hours 3.75 12.75 3.75 9.0 11.75
Total hours compensation 16.5 x \$25.00 = \$412.50 24.5 x \$25.00 = \$612.50
Invoice # & date submitted* 064491 07/06/89 064491 07/06/89
"UF Payables and Disbursements" \$60.25
Incidental Travel exp. reimb.- 06/30/89 \$108.50
Invoiced to UF Travel & Date 06/30/89

Total Interview Compensation: \$2912.50 Total Incidental Cost Replacement: \$505.07 = \$3417.57

* Invoicing date is a function of completion-time for required payee documentation and signature.

Bonnie Coats

SITE VISIT DATES: 01/16 01/27 02/09 02/10 02/26 03/08 03/09 03/10

Interview & travel hours 2.0 2.5 3.5 10.5 2.0 3.75 7.25 12.25

Total hours compensation 20.5 x \$25.00 = \$512.50 23.25 x \$25.00 = \$581.25

Invoice # & date submitted* 090489 03/31/89 113924 05/03/89

"UF Payables and Disbursements" \$119.90

Incidental Travel exp. reimb.- 02/13/89 03/15/89

Invoiced to UF Travel & Date

SITE VISIT DATES: 04/12 04/13 04/14 04/27 04/28

Interview & travel hours 3.75 16.5 3.75 3.75 10.75

Total hours compensation 24.0 x \$25.00 = \$600.00 14.5 x \$25.00 = \$362.50

Invoice # & date submitted* 113920 04/25/89 064487 05/31/89

"UF Payables and Disbursements" \$56.47

Incidental Travel exp. reimb.- 04/16/89 06/12/89

Invoiced to UF Travel & Date

SITE VISIT DATES: 05/10 05/11 05/12 05/31 06/01

Interview & travel hours 3.5 8.0 11.5 3.5 11.5

Total hours compensation 23.0 x \$25.00 = \$575.00 15.0 x \$25.00 = \$375.00

Invoice # & date submitted* 064487 05/31/89 064490 07/06/89

"UF Payables and Disbursements" \$60.25

Incidental Travel exp. reimb.- 06/12/89 06/30/89

Invoiced to UF Travel & Date

Total Interview Compensation: \$3006.25 Total Incidental Cost Replacement: \$478.57 = \$3484.82

* Invoicing date is a function of completion-time for required payee documentation and signature.